EBD

Employee Benefits Division

Health & Life Insurance

Enrollment Guide

Public School Employees

Enrollment Forms & Rate Information Inside!

Please keep as a reference throughout the Plan year.

Web: http://www.arkansas.gov/dfa/ebd | Email: AskEBD@dfa.state.ar.us

Tell Me What I Need To Know

Table of Contents

STATE OF ARKANSAS
Department of Finance and Administration

EMPLOYEE BENEFITS DIVISION
1515 West Seventh Street, Suite 300
Post Office Box 15610
Little Rock, Arkansas 72231-5610
Phone: (501) 682-9656
Toll Free: (877) 815-1017
Fax: (501) 682-1168
http://www.arkansas.gov/dfa/ebd

Dear Public School Employee:

Once again it is time to make choices regarding your health insurance coverage. I am sure the first thing you may do is to turn to the rate section of this booklet to see how much the rates have increased this year. The costs for health insurance for all Americans have continued to see double digit inflationary trends. Insurance companies and risk managers across the nation are looking at ways to address the health care crisis we are currently experiencing, and the State and Public School Employees Life and Health Insurance Board (the Board) is no exception.

One of the things the Board did last year was to make this group self-funded. This decision resulted in less of an increase than you would have seen had it remained fully-insured. We have reviewed the claims compared to premium income for the first 6 months and we are projecting a savings of from $3 to $4 million this year for your group's trust fund. That translates into about a 2% savings in insurance premium for you.

Remember a self-funded plan takes the insurance premiums paid by you and pays the claims and administrative expenses. There is no profit built into this program.

Over the past year, the Board has look at different plans that can address the issue of rising health care costs. The Board evaluated "Consumer Driven Health Plans" and the new "Health Savings Account" (HSA) provisions approved by the U S Congress and signed by President Bush in December of 2003. The Board decided on providing the HSA option to you for plan year 2005. This plan option provides you with more control over how you spend your health care dollars, in that it is a preferred provider option with a high deductible health insurance plan attached. You can contribute monies on a pre-taxed basis into the HSA that can be used for health care not covered through the plan; you can use it to meet your deductible, or you can allow it to sit there. It is your money. It will "roll over" each year so the "use it or lose it" rule does not apply.

You may contribute up to $1,500 for individuals or $3,000 for a family in the pre-taxed HSA per year. It is your money, so you can remove it from the account to use any way you choose; however, you will have to pay an excise tax as well as state and federal tax if it is used for non-approved medical reimbursement.

Employees and retirees over the age of 65 cannot participate in this plan under the provisions of Federal law. However, if you do participate in this plan prior to reaching the age of 65, at age 65 you can use it as you choose without paying the excise tax. This is one way the Federal Government is working to address the increasing cost of health care and the Board wanted to make this option available to you.

This year, you are experiencing increasing premiums AGAIN. Everything I read indicates the trends are running at a15.6% to 16% increase for 2004. Your plan is just under the national average at an overall 14% increase. For the first time your plan will cost more than $200 million a year. Actually the projected costs of care for the group for 2005 are $214 million. Using the mandatory amount of school contribution of $131 per participant per month set by legislation, the school contribution is $62 million and the employee contribution is just over $151 million. Some school districts will contribute more than $131 per participant a month, but many will not. This translates to you bearing the cost of the inflationary increases. This is especially apparent in the categories where dependents are covered.

Every year hundreds of employees call EBD and their school business officials asking us "Why does the insurance continue to increase?" Let me give you some of the reasons.

- Price Inflation: this represents the increase cost of health care services
- Utilization: this represents the number of claims incurred
- New Technology: this represents the introduction of new technology to the medical field and the associated cost
- Prescription Drug Costs: increased patient demand; introduction of new and expensive drugs; efforts by drug manufactures to increase their market share by direct to consumer advertising; bio-tech drugs (these are wonderful new drugs; however, they are very expensive).
- Aging population: your group's average age is over 45. Have you ever discussed why someone at another employer's insurance rates are less than yours when they are with the same insurance carrier? One of the reasons is age. As we age we develop chronic condtions that are very expensive to treat. The other groups are likely younger and their utilization is not nearly as high as your plan's utilization. We also cover our retirees where as most private employers do not.

All these reasons directly relate to the increased costs you see reflected in your insurance rates.

The Board worked very hard to provide an additional option (HSA with High Deductible Health Plan) for you. I hope you review this option and evaluate whether this is a good choice for you.

Please take note of a new section in this booklet about the enhanced Preventative Care Benefit that has eliminated the front end co-pays and deductibles for preventative care services no matter what plan you select. The Board, EBD and our health plan vendors are working in conjunction with Governor Huckabee's Healthy Arkansas initiative and hope you will take advantage of preventative health care options. The goal is to eventually identify the potential problems before they become chronic expensive conditions. That will result in a healthier population and reduced costs.

Sincerely,

Sharon Dickerson
Executive Director, Employee Benefits Division

Are There Any Plan Changes?

YES! Please see summary below...and look for more details inside!

- New health plan and vendor options. In addition to the health plan vendors and plans that you've had in years past, you now have new options.

  NovaSys Health, an Arkansas based health plan administrator, is an additional choice for HMO, POS and PPO plans. Also, NovaSys Health, in partnership with Arkansas based DataPath Administrative Services (DPAS), will offer a Health Savings Account PPO plan (HSA PPO) with a high deductible.

- The open enrollment period will begin on July 19th and end on August 31st. Your enrollment changes, declinations, or additions will be effective on October 1, 2004. Your district may have more specific deadlines for completing your open enrollment process.

- Online enrollment is available for the first time to public school employees. You can complete your enrollment forms on-line quickly, securely and easily. See additional details in this manual. Separate instructions will also be sent to you by mail.

- New Prescription Drug Benefits administrator, National Medical Health Card (NMHC Rx), will replace AdvancePCS as the Pharmacy Benefits Administrator for your health plan effective October 1, 2004. You will recieve a new prescription card but your prior prescription history will be transitioned to NMHC Rx. Co-payments will remain the same: $10 Generic, $25 Preferred/Formulary, and $50 Non-Preferred/Non-Formulary.

- The deductible for the Point of Service (POS), Preferred Provider Organization (PPO) and Health Savings Account PPO (HSA PPO) will be calculated on a Plan year basis. The only exception is the Blue Cross Blue Shield PPO which will be calculated on a calender year basis as it always has.

- Enhanced preventative care benefits to include FREE annual examinations starting October 1, 2004. No co-pays or deductibles to meet. Please see additonal details in this manual.

Who Is EBD?

Mission Statement

State of Arkansas
Department of Finance and Administration
Employee Benefits Division

The mission of the Employee Benefits Division is to manage the group health and life insurance programs and other select benefit programs for active and retired state and public school employees; and to build quality programs that operate in an efficient and effective manner to ensure responsive customer service, promote product education, affordability and accessibility.

Who Is EBD ?

Employees and Job Titles

ADMINISTRATION	
Sharon Dickerson	Executive Director
Doris Williams	Administrative Assistant
ACCOUNTING	
Leigh Ann Chrouch	Chief Fiscal Officer
Amy Tustison	Accounting Supervisor
Kristy Smith	Ledger Accountant Supervisor
Judy Everett	Accounts Receivable Supervisor
Gloria Lovelace	Cash Management & Reconciliation Specialist
Derek Brooks	Cash Management & Reconciliation Specialist
Wayne Woolfolk	Cash Management & Reconciliation Specialist
Rhonda Stane	Cash Management & Reconciliation Specialist
Margaret Bryant	Cash Receipts & Billing Specialist
Elizabeth Holland	Cash Receipts & Billing Specialist
Sherri Rattenbury	Accounts Payable Specialist
Rose Bethley	Accounts Payable Supervisor
COMMUNICATIONS	
Ashli Davis	Communications Director
Pat Minyard	Administrative Assistant
Tracy Spears	Receptionist
HEALTH & MEMBER SERVICES	
Susan Bumpas, RN	Health and Member Services Manager
Gail Cliff	Supervisor
Kathy Johnson	Senior Member Advocate / Insurance Investigator
Laurie Fowler	Senior Member Advocate
Janisa Hooks	Member Advocate
Mary Ann Jones	Member Advodate
OPERATIONS	
George Platt	Operations Manager
Donna Cook	Technical Coordinator
Erika Backus	Benefits Specialist
Sherry Bryant	Pharmacy Coordinator
Andy Cains	Technical Specialist
Barbara Elkins	Benefits Specialist
Stella Greene	Benefits Administration Coordinator
Paige Harrington	Media Technician
Mandy Manosittisak	Technical Specialist
PRIVACY/SECURITY	
Bob Sterling	Privacy/Security Officer
Vito Chiechi	HIPAA Advocate / Member Advocate
RETIREMENT	
Louise Mann	Retirement Manager
Shana Cotton	Benefits Specialist (School Retirees)
Lisa Weathers	Benefits Specialist (State Retirees)

Who Can Help Me?

Carrier Contact Information

HEALTH INSURANCE CARRIERS

Arkansas Blue Cross & Blue Shield (offers PPO Plan)
P. O. Box 2181
Little Rock, AR 72203
Toll Free ..... (800) 482-8416
E-mail ..... publicschoolemployees@arkbluecross.com
Web site address: ..... www.arkbluecross.com

Health Advantage (offers HMO and POS plans)
P. O. Box 8069
Little Rock, AR 72203
Toll Free ..... (800) 482-8416
E-mail ..... publicschoolemployees@arkbluecross.com
Web site address ..... www.healthadvantage-hmo.com

NovaSys Health (offers HMO, POS, PPO and HSA PPO plans)
P. O. Box 25230
Little Rock, Arkansas 72221
Local Office ..... (501) 975-4853
Toll Free ..... (800) 294-3557
Web site addres ..... www.novasyshealth.com

QualChoice/QCA (offers HMO and POS plans)
10825 Financial Centre Parkway, Suite 400
Little Rock, AR 72211
Toll Free ..... (800) 782-5246
Local Office ..... (501) 228-7111
E-mail ..... Select “Contact Us” button on website
Web site address ..... www.qcark.com

HEALTH SAVINGS ACCOUNT

DataPath (DPAS - Data Path Administration Services)
1601 West Park Drive, Suite 9
Little Rock, AR 72204
Local Office ..... (501) 687-6954
Toll Free ..... (877) 685-0655
E-mail ..... PSE@idpas.com
Web site address ..... www.idpas.com

PRESCRIPTION COVERAGE

NMHC Rx (National Medical Health Card Rx) replacing AdvancePCS, Eff. 10-1-04
320 Executive Court, Suite 201
LIttle Rock, AR 72205
Toll Free ..... (800) 880-1188
Web site address ..... www.nmhcrx.com
Click on “contact us” and then go to “Member Services” to send an email message.

NMHC Mail (Mail Order Pharmacy)
PO Box 407096
Ft Lauderdale, FL 33340-7096
Toll Free ..... (800) 881-1966
Web site address ..... www.nmhcmail.com

LIFE INSURANCE

USAble Life
320 West Capitol, Suite 700
P.O. Box 1650
Little Rock, AR 72203
Toll Free Customer Service ..... (800) 370-5856
Toll Free Life Claims ..... (800) 648-0271
Local Office ..... (501) 375-7200
Web site address ..... www.usablelife.com

BEHAVIORAL HEALTH, MENTAL HEALTH, SUBSTANCE ABUSE & StarEAP

Corphealth / STAR EAP
1701 Centerview Dr., Suite 101
Little Rock, AR 72211
Toll Free 1-866-378-1645
E-mail ..... customerservice@corphealth.com
Website site address ..... www.corphealth.com
On website, click “Members” and go to Member’s Login.
Use Username: STAREAP and Password: STAREAP

GENERAL BENEFIT INFORMATION AND ASSISTANCE

Employee Benefits Division (EBD)

(Mailing address)
P.O. Box 15610
Little Rock, AR 72201

(Physical address)
1515 West 7th, Suite 300
Little Rock, AR 72231-5610

Phone Numbers

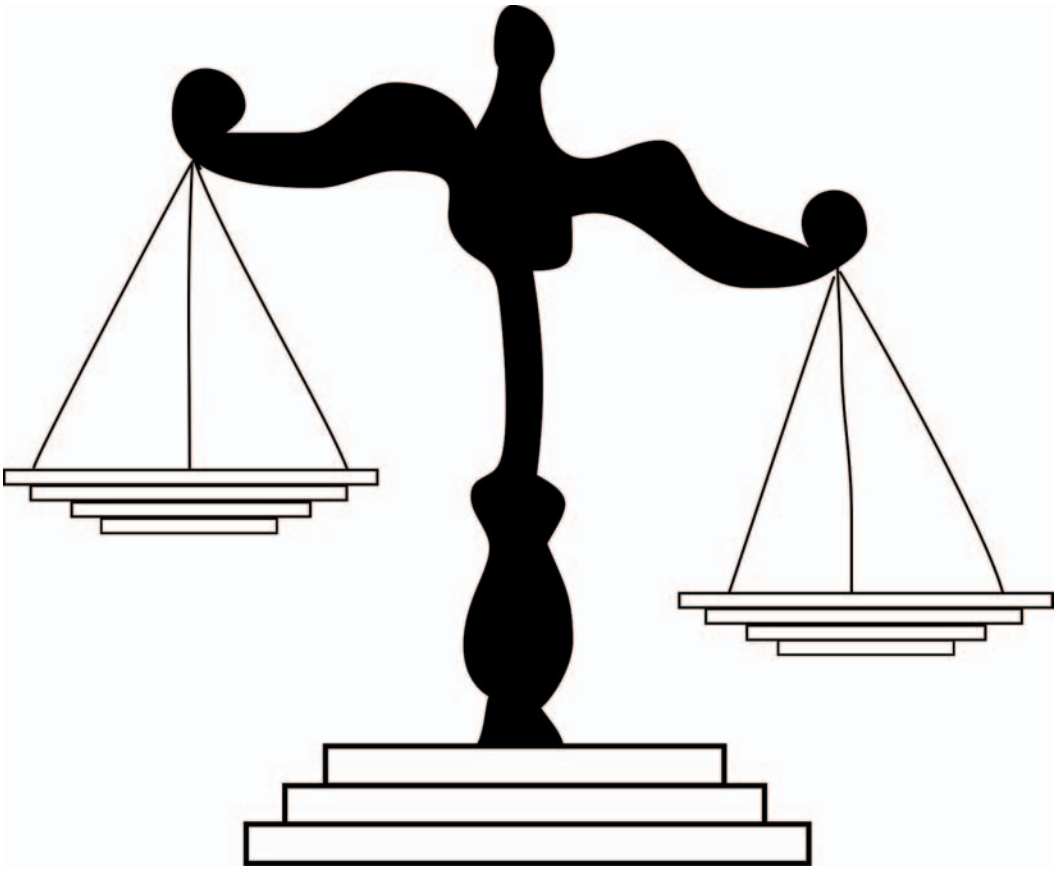
Toll Free ..... (877) 815-1017
Local Office ..... (501) 682-9656

Online

Public site address ..... www.arkansas.gov/dfa/ebd
ARBenefits system ..... www.ARBenefits.org
General E-mail Address ..... AskEBD@dfa.state.ar.us

What Are My Rights?

Health Information Portability and Accountability Act



The following four pages contain the Notice of Privacy Practices and the Authorization for Release of Health Information Form. These are for your reference and use as needed. It is not necessary to return the Authorization Form to EBD.

Notice of Privacy Practices

State of Arkansas
Department of Finance & Administration

Employee Benefit Division

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
Employee Benefits Division (EBD) is responsible for managing health benefits for the State of Arkansas and the Public School Employees. As a group health plan, EBD is required to secure the privacy of protected health information. The Notice of Privacy Practices describes the types of information, its uses and disclosures and your rights regarding that information.

"Protected Health information," (PHI) means information that is individually identifiable and is protected by privacy regulations. For example, information regarding the health care treatment, payment or operations that can identify you or your dependents. This information is obtained from enrollment forms for health care coverage, surveys, health care claims, specialist referrals, your medical records and other sources. You might provide protected health information by telephone, fax, letter or e-mail. Other sources of protected health information include, but are not limited to, health care providers, such as **insurance administrators, network providers, claims processors** (hereafter referred to as business partners or affiliates). **When used with health-related information, any of the following would be considered protected health information**:

- Marital status
- Name, address, and date of birth
- Information regarding dependents
- Gender
- Social Security Number
- Other similar information that relates to past, present or future medical care

Disclosures of protected health information not requiring authorization
The law allows the use and disclosure of protected health information without the authorization of the individual for the purpose of treatment, payment, and/or health care operations, which includes, but is not limited to:

- Treatment of a health condition
- Business planning and development
- Coordination of benefits
- Enrollment into the group health plan
- Eligibility for coverage issues
- Complaint review
- Regulatory review and legal compliance
- Payment for treatment
- Claims administration
- Insurance underwriting
- Premium billing
- Payment of claims
- Appeals review

Uses and disclosures for treatment: Your protected health information will be obtained from or disclosed to health care providers involved in your, or your dependents treatment.

Uses and disclosures for payment: Your protected health information will be obtained from and disclosed to individuals involved in your treatment for purposes of payment. Your protected health information may be shared with persons involved in utilization review, or other claims processing.

Uses and disclosures for health care operations: Your protected health information will be used and disclosed for Plan operations including, but not limited to, underwriting, premium rating, auditing, and business planning. In order to ensure the privacy of your protected health information, EBD has developed privacy policies and procedures. During the normal course of business, EBD may share this information with its business partners or affiliates that have signed a contract specifying their compliance with EBD's privacy policies.

NOTE: Only the minimum necessary amount of information to complete the tasks listed below will be disclosed.

Disclosures of personal health information requiring authorization

In all situations, other than outlined above, EBD will ask for your authorization to use or disclose your protected health information. EBD will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization.

- Usually, only the person to whom the protected health information pertains may make authorization.
- In some circumstances, authorization may be obtained from a person representing your interests (such as the case where you may be incapacitated and unable to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.
- Any third party acting as your advocate (for example, a family member, your employer or your elected official) would require an authorization

Forms

Forms may be obtained from EBD, Forms are:

- Authorization for Release of Information
- Revoking Authorization for Release of Information

Your Rights

- You have the right to review and copy your protected health information maintained by EBD. If you require a copy of PHI the first request will be provided to you at no cost. A reasonable fee will be charged for shipping additional or subsequent copies.
- You can request a copy of the Notice of Privacy Practices by EBD.
- You have the right to request an accounting, or list, of non-routine disclosures of your protected health information by EBD as of the compliance date. This request must be made in writing.
- You have the right to request a restriction on the protected health information that may be used and/or disclosed. You have the right to request that communications regarding your protected health information from EBD be made at a certain time or location. This request must be in writing and EBD reserves the right to refuse the restriction.
- You have the right to receive confidential communication of PHI at alternate locations and by alternate means.

If you believe your privacy rights have been violated, you have the right to register a complaint with EBD's Privacy Officer:

EBD Privacy Officer
P.O. Box 15610
Little Rock, AR 72231
(501) 682-9656

Or you can send your complaint to the Secretary of Health and Human Services:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

To e-mail the HHS Secretary or other Department officials, send your message to: HHS.Mail@hhs.gov.

Under the HIPAA regulations and guidelines, there can be no retaliation for filing a complaint.

Changes to Privacy Practices

If EBD changes its privacy policies and procedures, an updated Notice of Privacy Practices will be provided to you. Additional information, additional examples and up-to-date privacy notices are maintained on the EBD website at www.arkansas.gov/dfa/ebd.

This notice became effective on April 14, 2003.

STATE OF ARKANSAS
Department of Finance and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-1168 http://www.state.ar.us/dfa/ebd

Authorization for Release of Health Information

Health Plan Participant: _____

Home Address: _____

_____

School / Agency: _____

I authorize the use or disclosure of the above-named individual's health information as described below:

The following individuals or organizations are authorized to make the disclosure:
(School Business Official, Agency Representative, etc.)

_____ _____

The type and amount of information to be used or disclosed is as follows:
(check off appropriate item(s), and include other information, where indicated)

- ❑ Problem List
- ❑ Medication List
- ❑ List of allergies
- ❑ Immunization Record
- ❑ Most recent history and physical
- ❑ Most recent discharge summary
- ❑ Consultation reports from (please supply doctor's names) _____
- ❑ Laboratory results from _____ (date) to _____ (date)
- ❑ Entire record from _____ (date) to _____ (date)
- ❑ Other; please describe: _____

_____

This information may be disclosed to, and used by, the following individuals or organizations: *(providers, spouse, friends, etc.)*

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

By my signature below, I authorize disclosures to and by EBD.

This information is being disclosed for the following purpose:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the EBD Privacy Officer (on the header address.) I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months from the date of this signing.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may be protected by federal privacy regulations.

I understand that I need not sign this form in order to ensure health care treatment, payment enrollment in my health plan, or eligibility for benefits.

_____ _____

Signature of Health Care Participant or Legal Representative Date

_____

If signed by legal representative, print relationship to health care participant

_____ _____

Signature of Witness Date

I understand the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.

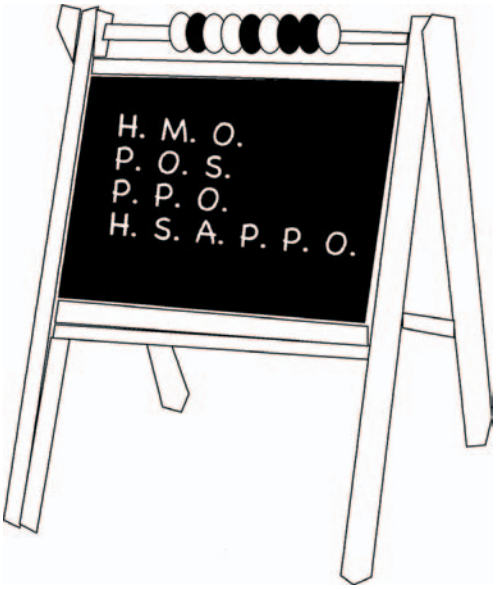
What Are My Choices?

Plan Overview

1. Health Maintenance Organization (HMO) *offered by*

- *** QualChoice of Arkansas**
- *** Health Advantage**
- *** NovaSys Health**

(Benefits are the same no matter which carrier is selected.)



Participants must select an in-network Primary Care Physician (PCP) to oversee all care.

Out-of-network physician visits or services are not covered.

No deductibles to meet.
$25 co-pay for PCP visit
$35 co-pay for in-network Specialist visit
$100 co-pay for outpatient treatment or surgery with 20% co-insurance for lab work

Out-of-pocket maximums are $1,500 per person or $3,000 per family, not including co-pays. Some services such as lab work, home health visits, therapy sessions, etc. carry a 20% co-insurance. The out-of-pocket maximum is reached by the sum of those co-insurance amounts within the Plan year. When the out-of-pocket maximum is reached, no further co-insurance amounts will be required that year. Co-pays will still be charged.

2. Point of Service (POS) *offered by*

- *** QualChoice of Arkansas**
- *** Health Advantage**
- *** NovaSys Health**

(Benefits are the same no matter which carrier is selected.)

POS plan has the same benefit structure as HMO plan when in-network and PCP services are rendered (same co-pay and out-of-pocket maximums listed in HMO description above).

Unlike the HMO plan, the POS plan allows out-of-network physician visits and hospital visits. Those services are subject to deductibles and 40% co-insurance similar to the PPO plan (described in the PPO section below).

* Out-of-pocket limits are: In-network $1,500 per person and $3,000 per family; Out-of-network $5,000 per person and $10,000 per family.

3. Preferred Provider Organization (PPO) offered by
*** Blue Cross Blue Shield of Arkansas**
*** NovaSys Health**

The PPO plan offers the greatest number of in-network physicians and hospitals but deductibles do apply before any benefits are paid:
In-Network - $500 individual deductible, $1,000 per family
Out-of-Network - $1,500 individual deductible, $3,000 per family

OUT-OF-POCKET LIMIT after deductible and co pays are:
In-Network - $3,000 per person and $6,000 per family
Out-of-Network - $8,000 per person and $16,000 per family

The majority of in-network services are covered at 80% by Plan, 20% by member after deductible and co-pays. Majority of out-of-network services are paid at 60% of health plan's maximum allowable, not 60% of billed charges. If provider does not accept maximum allowable, the member is responsible for the difference plus the remaining 40%.

4. Health Savings Account Preferred Provider Organization (HSA PPO)
*** NovaSys Health**

The HSA PPO offers a wide variety of in-network physicians and hospitals but a high deductible does apply before any benefits are paid. Also, participation in a separate Health Savings Account (HSA) is required with a minimum monthly contribution of $20. Please see additional HSA details in this manual.

Deductible (same for In and Out-of-Network Services):
$1,500 deductible for Individual Coverage
$3,000 deductible for Employee & Spouse, Employee & Children, and Family Coverage.*

(*The entire $3,000 deductible must be met by one or a combination of family members before any benefits are paid. Individuals within a family plan do not have a $1,500 individual deductible.)

Out-of-pocket limit after deductible is:
In-Network services, $2,500 per person and $5,000 per family.
Out-of-Network services, $5,000 per person and $10,000 per family.

The pharmacy benefit for participants in this Plan requires a plan year $50 front-end deductible (for each family member) which does not apply to the deductible listed above. After the $50 deductible is met, the usual pharmacy co-pay structure applies. Pharmacy co-pay payments do not apply toward the health plan deductible but are reimbursable under the Health Savings Account.

Please refer to the Summary Plan Descriptions, available from EBD or online, for more details. Also see maps in this section indicating in-network hospitals for each provider. Please refer to carrier websites or customer service centers for the most current provider information.

Health Savings Accounts ...
Your Newest Choice in Health Care

The Medicare bill that was signed by President Bush in December 2003 created an exciting new program called Health Savings Accounts, or HSA. An HSA is a personal savings account, owned by the individual, which can pay for medical expenses when they occur. An HSA empowers an individual with the tools to become a better health care consumer.

In order to take advantage of the HSA, you must be a member of the HSA PPO offered by NovaSys Health. This insurance plan has a higher deductible than the other insurance options but offers you lower monthly premiums and access to an HSA. There are many benefits to an HSA, but the best part is the significant tax savings offered through this plan. With an HSA, you can make contributions to the HSA, earn interest, and make withdrawals from the HSA, all Tax-Free.

The Benefits of a Health Savings Account

- Pre-Tax Payroll Contributions – You can make monthly contributions on a pre-tax basis, reducing the amount of taxes on your paycheck and increasing your overall take-home pay.
- Portability – You own your account, so when you retire or change jobs, your HSA goes with you.
- Affordable Health Coverage – You can use your Health Savings Account to cover 100% of the cost of routine medical expenses, office visits, lab tests, and over-the-counter drugs. The HSA can also be used for dental, vision or prescription medication as well.
- No “Use-it or Lose-it” – Contributions to your HSA that are not used this year, roll over year-after-year.
- Reduced Insurance Premiums – The rates for the HSA / PPO are the least expensive of any plan offered this year. This should not be the only reason to choose the HSA / PPO, but reducing the monthly premiums can provide you with a greater opportunity to save.
- Long-Term Savings – Because your funds can roll over from year to year, you can let your account grow and earn interest tax-free.
- Easy Access – The funds in your HSA can be withdrawn at any time for any reason. Distributions due to a qualified medical expense are Tax-Free whereas other distributions are subject to income and a 10% excise tax.
- Catch up Contributions – Individuals who are 55 or older can make an additional annual contribution of $500. This will help your nest egg to get started on the right foot.
- Coverage for the “Extras” – You can also use your HSA to pay for expenses not usually covered by health plans, including dental, vision, long-term care insurance, and much more.

Here is how an HSA works:

1. First, you must sign up for the specially designed insurance program called the HSA PPO offered by NovaSys Health.

2. Then, you make monthly contributions to your HSA. Each participant is required to contribute at least $20 a month through payroll deduction to the HSA. You may also make post-tax contributions to your account at any time. You can choose the contribution amount that is right for you and can contribute up to the maximum each year. The tier level you elect determines the contribution limit and it is based on the deductible amount for that tier. A person electing Employee Only can contribute up to $1,500 a year, while a person electing Employee & Spouse, Employee & Child(ren) or Employee & Family coverage can contribute up to $3,000 a year.

3. Finally, as you or your family members incur medical expenses, simply withdraw the money from your account. This can be done electronically through the Internet, or by submitting a paper form to DataPath Administrative Services (DPAS), your HSA Administrator.

Other Items to Consider:

The Health Savings Account regulations defines an eligible individual as someone being covered by a qualified high deductible health plan (NovaSys HSA PPO is a qualified health plan) and not covered by any other health plan that is not a high deductible health plan, and which provides coverage for any benefit covered by the high deductible health plan. For further clarification of this definition, go to www.Arkansashsa.com or e-mail the HSA administrator at PSE@idpas.com.

An individual who is 65 years of age or older may not participate in the HSA / PPO and, therefore, cannot participate in an HSA.

Active Employees can have their HSA contributions processed as a Pre-Tax deduction from their paycheck, saving them Federal, State and other payroll taxes.

For more information about Health Savings Accounts, please visit www.ArkansasHSA.com.

What Does Each Plan Cover?

Summary of Most Frequently Used Services

Important Note: The only out-of-network services covered under the pure HMO plans are emergency services and insurance company authorized referrals. The Point of Service (POS) out-of-network reimbursement of the health plan to the provider is 60% of the health plan's approved charges, not of the provider or facility's billed charges. For a more detailed explanation of what each plan covers and what is excluded, please refer to that plan's Summary Plan Description booklet, available from EBD.

PLAN HIGHLIGHT 2004-2005	PPO PLAN		HMO & POS PLAN		HSA PPO	
	IN NETWORK	OUT-OF NETWORK	IN NETWORK	POS OUT-OF NETWORK**	IN NETWORK	OUT-OF NETWORK
Deductible (first dollar out-of-pocket per plan year)	$500 per person $1,000*** per family	$1,500 per person $3,000*** per family	$0	$500 per person $1,000*** per family	$1,500 per person $3,000 per family	$1,500 per person $3,000 per family
Coinsurance/ Copayment	20% after deductible	40% after deductible	Per office visit: $25 PCP $35 Specialist	40% after deductible of maximum allowable ammount	20% after deductible	40% after deductible
Out-of-Pocket Limit (after deductible co-pays)	$3,000 per person $6,000*** per family	$8,000 per person $16,000*** per family	$1,500 per person $3,000*** per family	$5,000 per person $10,000*** per family	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family
Physician Services	20% Coinsurance	40% Coinsurance	Per office visit: $25 PCP $35 Specialist	40% Coinsurance of maximum allowable	20% Coinsurance	40% Coinsurance
Inpatient	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Outpatient	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Outpatient Services	20% Coinsurance	40% Coinsurance	20% Coinsurance after $100 co-pay for Outpatient Surgical facility	40% Coinsurance of maximum allowable	20% Coinsurance	40% Coinsurance
Diagnostic Testing (Lab and X-Ray)	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Ambulance $1,000 annual limit	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Inpatient Hospital	20% Coinsurance	40% Coinsurance	$500 Co-pay + 20% coinsurance per admission with maximum 3 co-pays per member per year	40% Coinsurance of maximum allowable amount	20% Coinsurance	40% Coinsurance

*****Out-of-Network benefits apply when you do not visit your PCP or follow the Plan's referral procedures when visiting a specialist or hospital.**

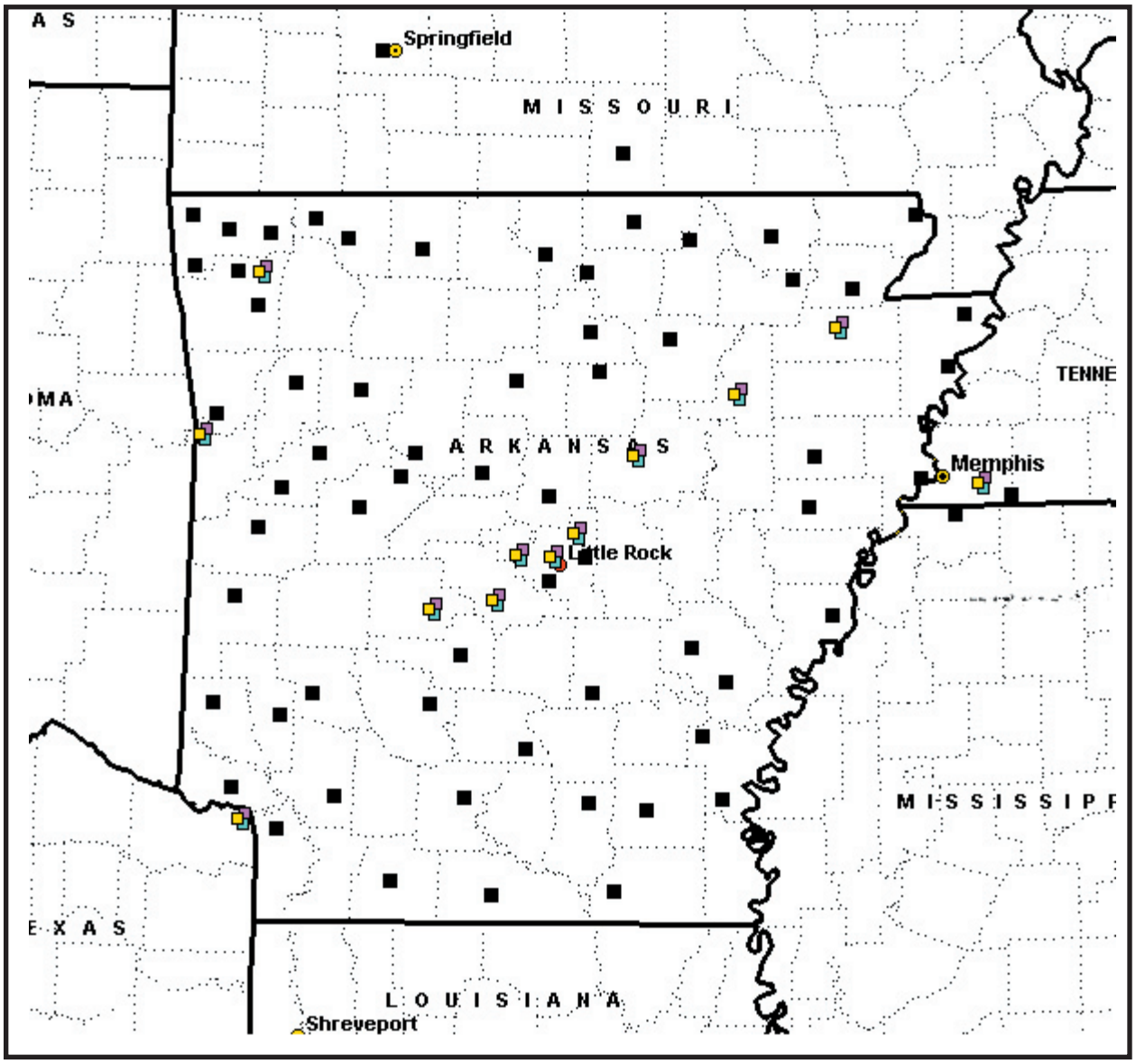
PLAN HIGHLIGHT 2004-2005	PPO PLAN		HMO & POS PLAN		HSA PPO	
	IN NETWORK	OUT-OF NETWORK	IN NETWORK	POS OUT-OF NETWORK**	IN NETWORK	OUT-OF NETWORK
Preventative Care: First dollar coverage with no deductible or co-pay	Covered	Not Covered	Covered	Not Covered	Covered	Not Covered
Mental Health / Substance Care / Physician Inpatient & Outpatient	Please refer to page 29	Please refer to page 29	Please refer to page 29	Please refer to page 29	20% Coinsurance	40% Coinsurance
					Covered through Corphealth but subject to Plan deductible and coinsurance	
Home Infusion IV drugs and solutions	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
Emergency Care	20% Coinsurance	20% Coinsurance	$100 copay + 20% coinsurance, co-pay waived if admitted to same hospital	$100 co-pay + 20% coinsurance, co-pay waived if admitted to same hospital	20% Coinsurance	40% Coinsurance
Transplants	Must be approved by Plan, then 20% coinsurance	Must be approved by Plan, then 40% coinsurance	Must be approved by Plan, then $500 co-pay per admisssion + 20% coinsurance	Not Covered	Must be approved by Plan, then 20% Coinsurance	Not covered out of network
	* Travel and lodging allowance up to $10,000 ouside service area.					
Durable Medical Equipment Annual Maximum $10,000	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
DME Repairs	Must be approved by plan	Must be approved by plan	Must be approved by Plan	Must be approved by Plan	Must be approved by Plan	Must be approved by Plan
Physical, Occupational and Speech Therapy, Chiropractic Services and Cardiac Rehabilitation	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
	(Limited to 60 combined visits per member per year)					
Allergies	20% Coinsurance	40% Coinsurance	20% Coinsurance for injections $25 Co-pay PCP $35 Co-pay Specialist	40% Coinsurance	20% Coinsurance	40% Coinsurance
Home Health Nursing Visits 120 Annual Visits	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance

*****Out-of-Network benefits apply when you do not visit your PCP or follow the Plan's referral procedures when visiting a specialist or hospital.**

PLAN HIGHLIGHT 2004-2005	PPO PLAN		HMO & POS PLAN		HSA PPO	
	IN NETWORK	OUT-OF NETWORK	IN NETWORK	POS OUT-OF NETWORK**	IN NETWORK	OUT-OF NETWORK
Maternity Benefits	Physician: 20% Coinsurance Hospital: 20% Coinsurance	Physician: 40% Coinsurance Hospital: 40% Coinsurance	Physician: 20% Coinsurance, co-pay for initial office visit Hospital: $500 co-pay per admission + 20% coinsurance; subject to the inpatient yearly maximums	Physician: 40% Coinsurance Hospital: 40% Coinsurance	Physician: 20% Coinsurance Hospital: 20% Coinsurance	Physician: 40% Coinsurance Hospital: 40% Coinsurance
Maximum Benefits	No Maximum	$1,000,000	No Maximum	$1,000,000	No Maximum	$1,000,000
Ostomy Supplies	10% Coinsurance	40% Coinsurance	10% Coinsurance	40% Coinsurance	10% Coinsurance	40% Coinsurance
Prosthetic	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance	20% Coinsurance	40% Coinsurance
	$15,000 annual limit					
Pharmacy Benefit through NMHC Rx	$5.00 Co-pay Prilosec OTC $10.00 Co-pay Generic $25.00 Co-pay Preferred Drugs $50.00 Non-preferred Non-covered drugs 100% member responsibility				$50 plan year front-end deductible per person, then copayment schedule at left applies	

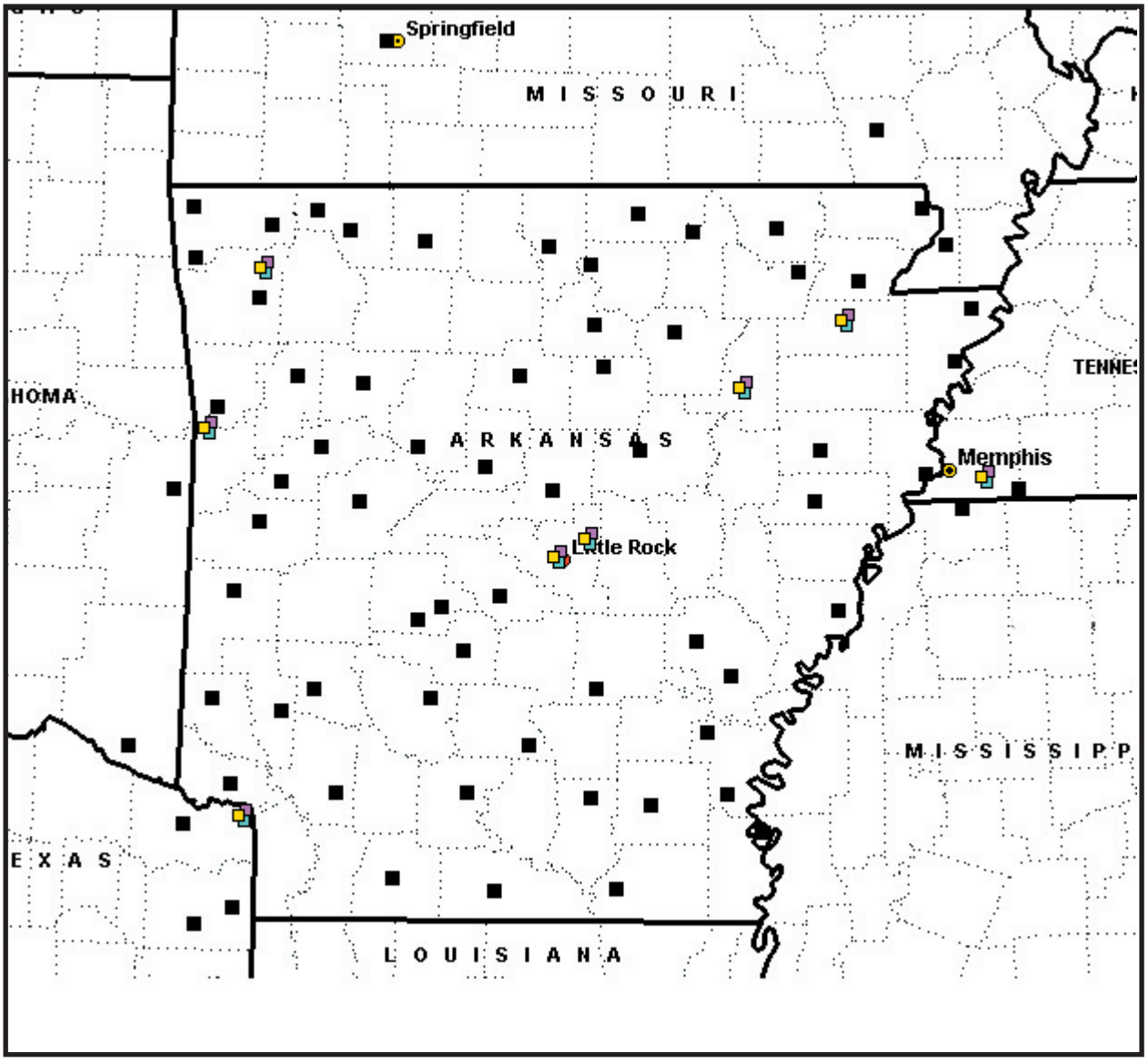
*****Out-of-Network benefits apply when you do not visit your PCP or follow the Plan's referral procedures when visiting a specialist or hospital.**

Arkansas Blue Cross & Blue Shield
Hospital Network



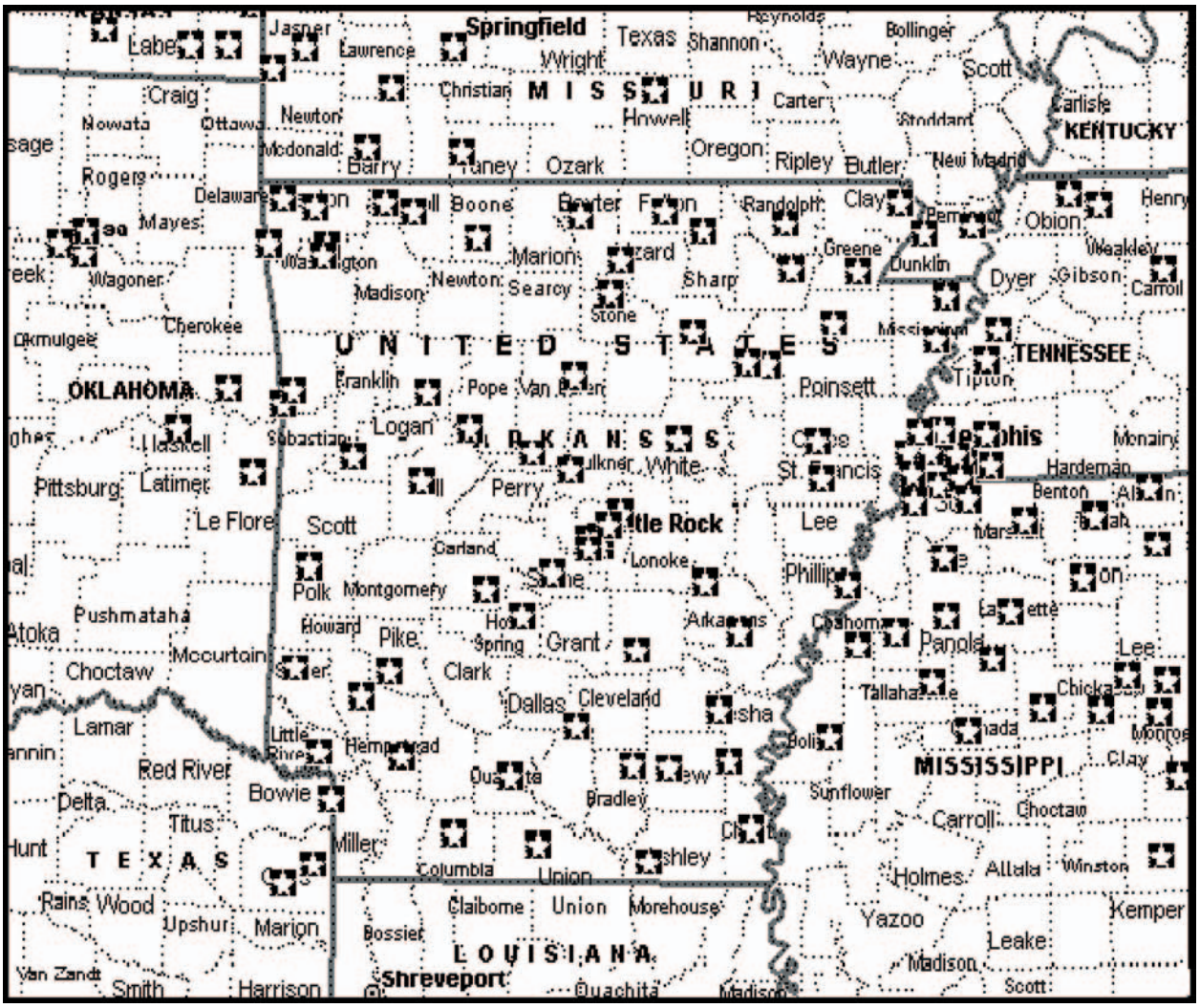
Please refer to the provider website or call their customer service line for the most up-to-date hospital and provider information.

Health Advantage HMO & POS
Hospital Network



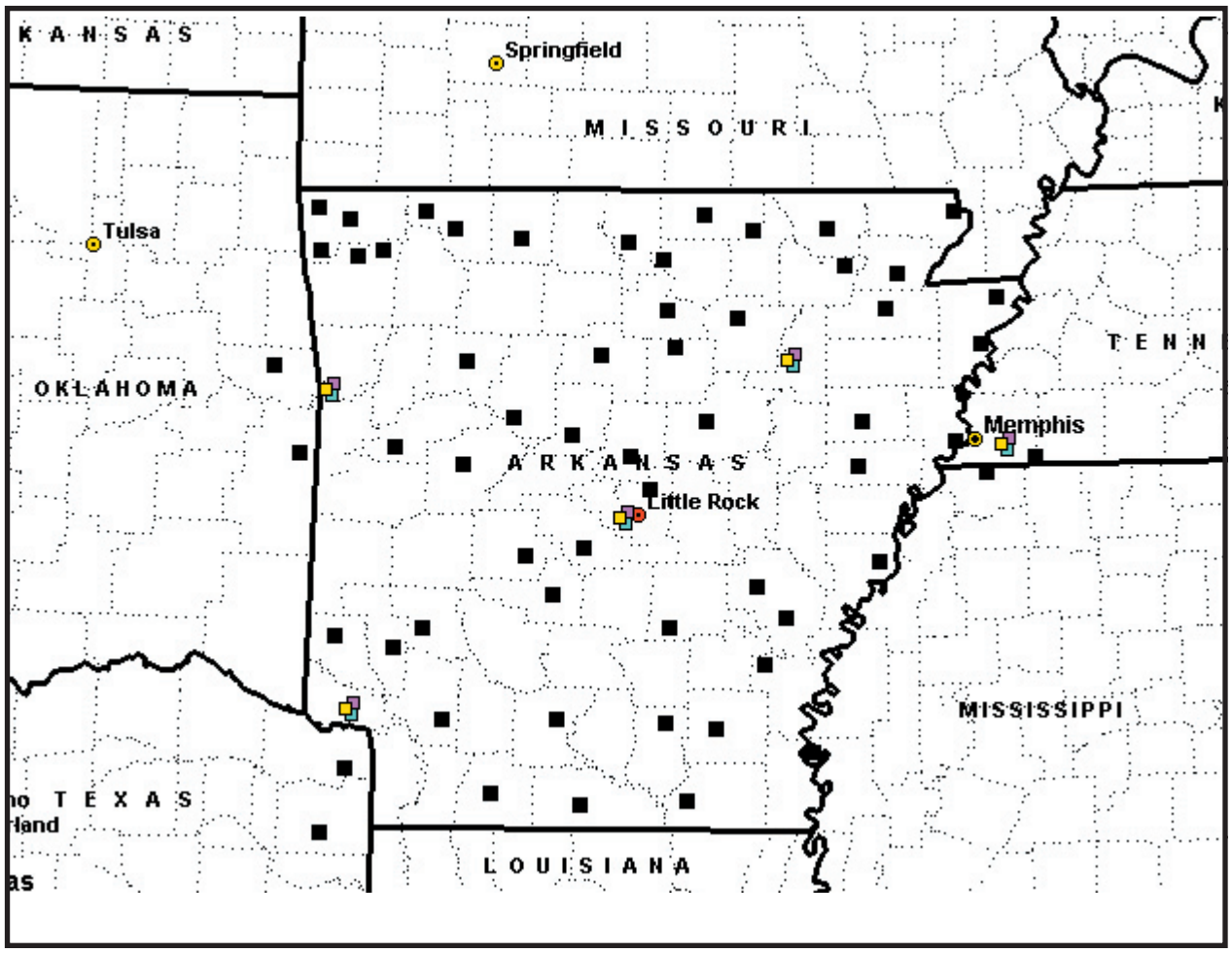
Please refer to the provider website or call their customer service line for the most up-to-date hospital and provider information.

NovaSys HMO, POS & PPO
Hospital Network



Please refer to the provider website or call their customer service line for the most up-to-date hospital and provider information.

QualChoice HMO & POS
Hospital Network



Please refer to the provider website or call their customer service line for the most up-to-date hospital and provider information.

What Else Comes With Those Plans?

Additional Programs Included With The Health Plans

Prescription Drug Program

Your prescription drug program is a stand-alone, self-insured plan, which is included with your group health insurance plan and administered by NMHC Rx effective October 1, 2004. New and existing plan enrollees will automatically receive a prescription drug card that offers important savings on your prescribed medication in the HMO, POS and PPO plan. There is a $50 annual deductible in the NovaSys high deductible HSA plan.

The copays for up to a 34-day supply of medicine, the copayment structure is:

- $5 for Prilosec OTC
- $10 for generic drugs
- $25 for “formulary” brand-name drugs
- $50 for “non-formulary” brand-name drugs

100% payment for all other drugs not covered by the Plan.

Selecting a Pharmacy

There are thousands of participating pharmacies nation-wide and most of your local Arkansas pharmacies will honor your NMHC Rx prescription drug card. For more information about participating pharmacies, including pharmacies in other states, contact NMHC Rx Customer Service at 1-800-880-1188.

Should you find it necessary to fill prescriptions at a non-participating pharmacy, please use the following procedure:

- You must pay the entire cost of the prescription at the point-of-sale because the pharmacy does not recognize our co-pay structure.
- A paper claim must be completed and submitted to NMHC Rx along with receipt from the purchase. That claim form can be obtained at the NMHC Rx website, www.nmhcrx.com.
- NMHC Rx will reimburse you the difference between the contracted drug cost and the regular copay for that prescription ($5, $10, $25, or $50). NOTE: The contracted price and the retail price are usually different; you will be responsible for that difference. **They will also deduct $1.25 for processing.**
- **You will save money if you use a participating pharmacy whenever possible.** A complete list is available at www.nmhcrx.com or by calling NMHC Rx customer service at 1-800-880-1188.

Mail Order Pharmacy Program

A mail service prescription benefit is available. Most maintenance medications are available through the mail order provider, NMHC Rx, including insulin and other diabetic supplies. Medications will be filled with a 90-day supply for the cost of three (3) standard retail copays. Also, you can recieve the same three (3) months supply of maintenance drugs for three (3) copays at your local pharmacy. For more information about the mail service benefit or for a complete list of excluded drugs, please call NMHC Rx at 1-800-881-1966 or visit their website, www.nmhcmail.com.

Managing The Prescription Drug Program

Your prescription drug program is designed to provide the greatest benefit to the entire group of state and public school employees. This program requires: Prior Authorization (PA) of some medications, Quantity vs. Time (QVT) restrictions are intended to clarify the usual quantity that constitutes a 34-day supply for particular medications, and Daily Dose Edits in order to eliminate inappropriate utilizations of medications intended for one daily use. “Step-therapy” is a treatment approach in which more traditional and less expensive medications are encouraged before graduation to newer, more expensive, and more sophisticated medicines. If this criteria is not met, the prescription would be denied and the member may choose to attempt Prior Authorization. The Formulary (Preferred Drug List) is a dynamic entity that will change at least every three (3) months. As new drugs become available they may be added to the formulary and other drugs may be removed from the formulary as generic drugs become available. Drugs may also be removed from the formulary and replaced by other drugs deemed to be more appropriate for our membership. For more information contact NMHC Rx toll-free at 1-800-880-1188.

Generic Drugs

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you and your doctor authorize generic substitution, it permits the pharmacy to dispense a generic drug. This saves you and your pharmacy program money. Whenever possible, ask your doctor to prescribe generic drugs.

Diabetic supplies are available without a co-pay at your local pharmacy if diabetic medicine is purchased at the same time.

NMHC Rx Web Site

A custom NMHC Rx website is being developed for our members. The address is www.nmhcrx.com. Members can also obtain information on the mail order pharmacy program through this site.

Life Insurance Benefits

Active Public School employees who participate in any of the health plans sponsored by the State and Public School Employee Life and Health Insurance Board will be automatically enrolled in $5,000 of Basic Group Term Life and Accidental Death and Dismemberment (AD&D) coverage with USAble Life.

In addition to the Basic Group Term Life and AD&D, you are eligible to participate in USAble's Supplemental Life and AD&D program. This program allows you to obtain up to $70,000 in Supplemental Life benefits. (Benefit amounts are based on your annual salary). You may also elect $2,500 of coverage on each of your eligible dependents.

To determine the amount of Supplemental Life for which you qualify, or for more details regarding your Group Term Life insurance, contact your district's business office.

Enrollment

New employees will have 30 days from their hire date to enroll in the Supplemental Life program without evidence of insurability. If you are currently insured by the Public School Employee group health plan, but have not elected the Supplemental Life, you may apply by providing evidence of insurability. Please contact your district office to obtain a Supplemental Life application.

Basic Life Insurance Rates

Public School Employees pay $0.65 a month for $5,000 basic life and AD&D insurance. This premium amount is included in the health insurance premium, and EBD remits this premium to USAble.

Supplemental and Dependent life insurance can be purchased as follows:

Supplemental Life/AD&D		
Annual Earnings	Insurance Amount	Monthly Premium
$10,000 or less	$20,000	$ 5.00
$10,001 - $15,000	$30,000	$ 7.50
$15,001 - $20,000	$40,000	$10.00
$20,001 - $25,000	$50,000	$12.50
$25,001 - $30,000	$60,000	$15.00
$30,001 and above	$70,000	$17.50

Dependent Life	
Coverage Amount	Monthly Premium
$2,500	$1.20

Premium for Supplemental and Dependent Life should be deducted from payroll and remitted directly to USAble Life once a bill is received from them.

Enrollment forms for Supplemental and Dependent Life and other correspondence should be sent directly to USAble Life and not EBD. See USAble Life contact information in "Contacts" section.

Mental and Behavioral Health Benefits

CORPHEALTH coordinates ALL behavioral health care for Arkansas Public School Health Care enrollees. Your benefit program and network of mental health care providers are completely separate from your medical, no matter which medical plan you select. Mental Health and Substance Abuse and an Employee Assistance Program (EAP), named the StarEAP, are included in the Behavioral Health Care Benefit.

You must access your behavioral health care benefit by calling the Arkansas Helpline and a CORPHEALTH network provider must deliver your care.

The benefits include the StarEAP and a chemical dependency benefit. **You do not have to obtain a referral from your Primary Care Physician to seek help from the StarEAP Employee Assistance Program or to access your mental health or substance abuse benefits**. All contact with Corphealth is strictly confidential.

Access is easy. Simply call the Arkansas Help Line toll-free at 1-866-378-1645 24 hours a day, 365 days a year.

- You'll have immediate access to a professional to help you assess your needs, sort through your options, and find effective resources.
- Telephonic and/or face-to-face sessions with one of the EAP affiliate counselors.
- Pre-certification for mental health and substance abuse treatment.
- Individualized referrals to resources in your community.

The StarEAP program provides you with short-term assessment and counseling with no copay for you or your covered dependents. The StarEAP provides immediate access to a clinical assessment and outpatient EAP treatment of up to eight (8) sessions, and/or referral to a behavioral health (mental health or chemical dependency) specialist that is covered under the plan at the benefit schedule summarized on the next page:

The StarEAP benefits include a complete range of services such as:

Emotional Well-Being	**Addiction & Recovery Assessments & Referrals to Specialist**
• Personal relationships • Marriage and family issues • Divorce and separation • Coping with violence • Grief and loss	• Alcohol and drugs • Gambling • Other addictions • Support groups • Eating disorders
Parenting	**Work**
• Single parenting and blended families • Discipline, setting limits and safety • Child development	• Work and personnel issues • Adjusting to change in the workplace • Stress management
Financial	**Legal**
• Budgeting • Managing credit and collections problems	• Referral to community resources

Key Things to Remember:

- Always access the benefit by first calling the Arkansas Help Line, 1-866-378-1645.
- **All services require pre-authorization.**
- Information about providers and benefits is available at www.corphealth.com. There will be no benefit for non-CORPHEALTH network providers where the care is not directed by CORPHEALTH, Inc., or is not an emergency.
- Always obtain a referral authorization from your CORPHEALTH case manager by calling the Arkansas Help Line at 1-866-378-1645.

Benefit Description	HMO, POS & PPO		HSA PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee Assistance Program (EAP) Star EAP Telephonic Consultation and Face-to-Face Short Term/ Brief Issue Resolution Counseling	Up to eight (8) EAP sessions per episode with no copayment. Must call Arkansas Help Line at 1-866-378-1645	Not Covered	Up to eight (8) EAP sessions per episode with no co-payment. Must call Arkansas Help Line at 1-866-378-1645	Not Covered
Initial Behavioral Health Benefit	Must call Arkansas Help Line at 1-866-378-1645	Not Covered	Must call Arkansas Help Line at 1-866-378-1645	Not Covered
Deductible	Subject to Plan deductible	Subject to Plan deductible	Subject to Plan deductible	Subject to Plan deductible
Copayment for Traditional Out-Patient Services	$35 co-pay / office visit	$35 co-pay + 25% coinsurance	20% Coinsurance	40% Coinsurance
Out-of-Pocket Maximum (After copays and deductibles)	$1,500 Individual $3,000 Family	$1,875 Individual $3,750 Family	Same as health plan	
Out-Patient Services (Partial hospital/day treatment)	$100 Co-pay + 20% Coinsurance	$125 Co-pay first visits + 45% Coinsurance	20% Coinsurance	40% Coinsurance
Out-Patient Services (Intensive Outpatient)	$100 Co-pay + 20% Coinsurance	$125 Co-pay first visits + 45% Coinsurance	20% Coinsurance	40% Coinsurance
Residential Treatment	20% Coinsurance	45% Coinsurance	20% Coinsurance	40% Coinsurance
In-Patient Services	$500 Co-pay + 20% coinsurance per admission	$625 Co-pay + 45% coinsurance per admission	20% Coinsurance	40% Coinsurance

All mental health or substance abuse services must be pre-authorized by CORPHEALTH prior to receiving care. All mental health and substance abuse claims for care rendered must be submitted to:

Claims Department
CORPHEALTH, Inc.
1701 Centerview Dr., Suite 101 Little Rock, AR 72211

Visit the CORPHEALTH web site at www.corphealth.com/members. State of Arkansas Plan Members can access custom plan information by logging in with the user name “STAREAP” and password, “STAREAP” from this page.

Inpatient

For all enrollees receiving inpatient care in an acute, partial hospitalization, residential treatment or intensive outpatient program level of care, the current Health Plan is responsible for managing the care and processing the claim until the enrollee has been discharged from that level of care. You must call CORPHEALTH at 1-866-378-1645 to pre-certify any care that may be necessary after you are discharged from any of the above-mentioned treatment levels.

Please contact the Arkansas Help Line toll-free at 1-866-378-1645 (7 days a week, 24 hours a day) if you have additional questions.

Frequently Asked Questions
about Corphealth and StarEAP

What is the difference between the StarEAP and Managed Care benefit?

StarEAP is designed to help you resolve short term problems related to work, relationships, parenting, finances, school, elder care, etc. And does not require a referral from your primary care physician.

Managed Care is designed to address medically diagnosed mental health problems which require treatment for a period of three months or more. Treatment can include medication, psychiatric/ psychological evaluation, individual, group or family therapy. You receive unlimited sessions, as long as they are medically necessary. There is a co-pay.

Do I have a choice of providers?

Yes. There are licensed clinicians (master's level, doctorate level and MDs) throughout the state and you can go to any provider in the Corphealth network, statewide. You can call Corphealth directly or go to their website www.corphealth.com for a current list of providers.

Note: If you require medical care for a mental health problem you must use a hospital in your medical plan's network.

Is my family eligible for mental health benefits?

School employees are eligible for StarEAP benefits if enrolled. Family members can participate in couple or family sessions with the employee. Enrollees in the health plan and their enrolled dependents are eligible for managed care benefits.

Will my employer know if I use StarEAP?

Your use of the EAP benefit is strictly confidential. In order for information about your participation the EAP to be released to anyone, you must sign an authorization to release information. Employers can refer you to the EAP if they feel it can be of help to you, if they are concerned about your work performance or if you have a drug free work policy and test positive for a drug screen. Employer referrals to the EAP may require your participation in the EAP, but again, **you must sign a release in order for your information to be shared with your employer.**

NEW! PREVENTATIVE CARE BENEFIT ENHANCEMENT

Effective October 1, 2004, all of the health plans (HMO, POS, PPO and HSA PPO) will have an expanded preventative health care benefit to include at NO COST annual examinations for adults and dependent children. These services will not be subject to a co-payment or deductible and are available once every plan year for each covered individual on the plan.

The following criteria must be met to take advantage of this benefit:

1. Use In-Network Physicians – review your health plan's provider directory for an up-to-date list of participating providers

2. Get the preventative services from the following types of physicians only:
   - Primary Care Physician (PCP)
     - o General Practitioner
     - o Family Practitioner
     - o Pediatrician (for children)
     - o Internal Medicine Physician
   - Obstetrician/Gynecologist (Ob/Gyn)

3. Instruct your physician to use the appropriate billing (or CPT) codes to ensure full payment of these procedures:

Over age 18 use these codes

Annual Preventative Care Visit	99385 through 99387 99395 through 99397

Under age 18 use these codes

Annual Preventative Care Visit	99382 through 99384 99392 through 99394
Well Baby Visits	99381, 99391, 99432

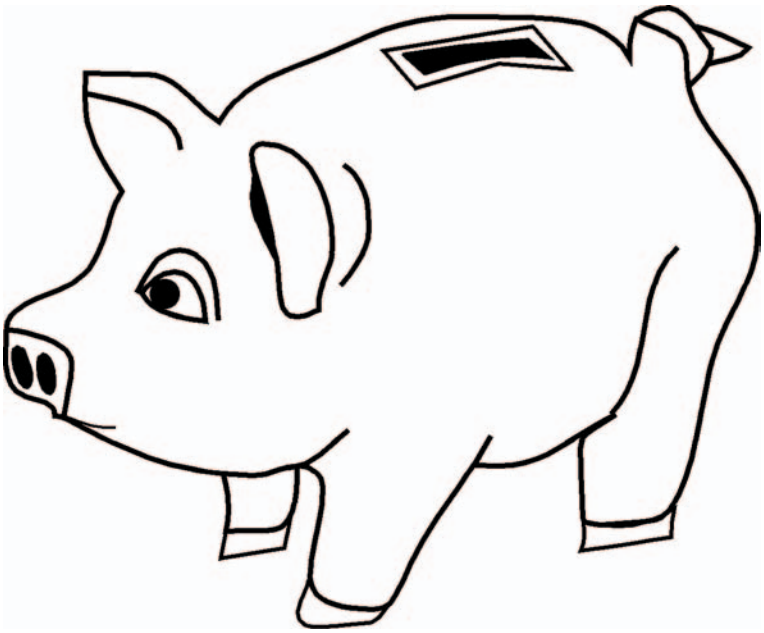
Other preventative services associated with these visits such as immunizations, cholesterol and HDL screening, cancer screening, and screening mammogram will also be fully covered.

Use of these services and the associated cost to the health plan will not count against any deductible or annual out-of-pocket limit.

How Much Will This Cost Me?

Rates for the 2004-2005 Plan Year

- **Active Employees**
- **Retirees Not Medicare Primary**
- **Retirees Medicare Primary**
- **COBRA**



Public School Health Plan Options & Rates for Active Employees

Effective October 1, 2004 - September 30, 2005, Self-Insured Health Plan

	Total Monthly Insurance Premium	Minimum District Contribution	*TOTAL MONTHLY EMPLOYEE COST	Health Savings Account	
				*HSA Mandatory Minimum Monthly Account Contribution	*HSA PPO Total Minimum Monthly Employee Cost
Employee Only					
Blue Cross Blue Shield PPO	**$310.76**	($131.00)	**$179.76**	-	-
NovaSys PPO	**$310.24**	($131.00)	**$179.24**	-	-
Health Advantage POS	**$287.78**	($131.00)	**$156.78**	-	-
NovaSys POS	**$287.26**	($131.00)	**$156.26**	-	-
QualChoice POS	**$310.84**	($131.00)	**$179.84**	-	-
Health Advantage HMO	**$279.28**	($131.00)	**$148.28**	-	-
NovaSys HMO	**$278.78**	($131.00)	**$147.78**	-	-
QualChoice HMO	**$293.48**	($131.00)	**$162.48**	-	-
***NovaSys HSA PPO (High Deductible)**	**$256.28**	($131.00)	**$125.28**	$20.00	**$145.28**
Employee & Spouse					
Blue Cross Blue Shield PPO	**$821.98**	($131.00)	**$690.98**	-	-
NovaSys PPO	**$821.48**	($131.00)	**$690.48**	-	-
Health Advantage POS	**$757.84**	($131.00)	**$626.84**	-	-
NovaSys POS	**$757.34**	($131.00)	**$626.34**	-	-
QualChoice POS	**$822.14**	($131.00)	**$691.14**	-	-
Health Advantage HMO	**$734.16**	($131.00)	**$603.16**	-	-
NovaSys HMO	**$733.64**	($131.00)	**$602.64**	-	-
QualChoice HMO	**$773.72**	($131.00)	**$642.72**	-	-
***NovaSys HSA PPO (High Deductible)**	**$658.30**	($131.00)	**$527.30**	$20.00	**$547.30**
Employee & Child(ren)					
Blue Cross Blue Shield PPO	**$539.92**	($131.00)	**$408.92**	-	-
NovaSys PPO	**$539.40**	($131.00)	**$408.40**	-	-
Health Advantage POS	**$498.52**	($131.00)	**$367.52**	-	-
NovaSys POS	**$498.02**	($131.00)	**$367.02**	-	-
QualChoice POS	**$540.06**	($131.00)	**$409.06**	-	-
Health Advantage HMO	**$483.26**	($131.00)	**$352.26**	-	-
NovaSys HMO	**$482.76**	($131.00)	**$351.76**	-	-
QualChoice HMO	**$508.76**	($131.00)	**$377.76**	-	-
***NovaSys HSA PPO (High Deductible)**	**$436.50**	($131.00)	**$305.50**	$20.00	**$325.50**
Employee & Family					
Blue Cross Blue Shield PPO	**$830.60**	($131.00)	**$699.60**	-	-
NovaSys PPO	**$830.08**	($131.00)	**$699.08**	-	-
Health Advantage POS	**$766.24**	($131.00)	**$635.24**	-	-
NovaSys POS	**$765.72**	($131.00)	**$634.72**	-	-
QualChoice POS	**$830.80**	($131.00)	**$699.80**	-	-
Health Advantage HMO	**$742.50**	($131.00)	**$611.50**	-	-
NovaSys HMO	**$742.00**	($131.00)	**$611.00**	-	-
QualChoice HMO	**$782.18**	($131.00)	**$651.18**	-	-
***NovaSys HSA PPO (High Deductible)**	**$665.16**	($131.00)	**$534.16**	$20.00	**$554.16**

**Participation in the "HSA PPO (High Deductible)" plan and the Health Savings Account (HSA) are tied. A minimum mandatory member contribution of $20.00 per month to the HSA is required for participation in the NovaSys HSA High Deductible PPO plan. The Health Savings Account must adhere to federal guidelines. See far right column for total minimum monthly cost.*

Public School Employees - Retirees not Medicare Primary

Effective October 1, 2004 - September 30, 2005, Self-Insured Health Plan

	Total Monthly Premium	School Contribution	*TOTAL MONTHLY RETIREE COST	Health Savings Account	
				'HSA Mandatory Minimum Monthly Account Contribution	*HSA PPO TOTAL Minimum Monthly Employee Cost
Retiree Only					
BCBS PPO	$561.27	($80.29)	$480.98	-	-
NovaSys PPO	$560.77	($80.29)	$480.48	-	-
Health Advantage POS	$497.37	($80.29)	$417.08	-	-
NovaSys POS	$496.87	($80.29)	$416.58	-	-
QualChoice POS	$546.79	($80.29)	$466.50	-	-
Health Advantage HMO	$488.75	($80.29)	$408.46	-	-
NovaSys HMO	$488.23	($80.29)	$407.94	-	-
QualChoice HMO	$514.63	($80.29)	$434.34	-	-
***High Deductible PPO**	$448.83	($80.29)	$368.54	$20.00	$388.54
Retiree & Spouse					
BCBS PPO	$1,069.49	($80.29)	$989.20	-	-
NovaSys PPO	$1,068.99	($80.29)	$988.70	-	-
Health Advantage POS	$946.89	($80.29)	$866.60	-	-
NovaSys POS	$946.39	($80.29)	$866.10	-	-
QualChoice POS	$1,041.69	($80.29)	$961.40	-	-
Health Advantage HMO	$930.35	($80.29)	$850.06	-	-
NovaSys HMO	$929.85	($80.29)	$849.56	-	-
QualChoice HMO	$979.99	($80.29)	$899.70	-	-
***High Deductible PPO**	$848.27	($80.29)	$767.98	$20.00	$787.98
Retiree & Child(ren)					
BCBS PPO	$810.23	($80.29)	$729.94	-	-
NovaSys PPO	$809.71	($80.29)	$729.42	-	-
Health Advantage POS	$716.97	($80.29)	$636.68	-	-
NovaSys POS	$716.47	($80.29)	$636.18	-	-
QualChoice POS	$789.09	($80.29)	$708.80	-	-
Health Advantage HMO	$704.39	($80.29)	$624.10	-	-
NovaSys HMO	$703.87	($80.29)	$623.58	-	-
QualChoice HMO	$742.15	($80.29)	$661.86	-	-
***High Deductible PPO**	$644.43	($80.29)	$564.14	$20.00	$584.14
Retiree & Family					
BCBS PPO	$1,224.11	($80.29)	$1,143.82	-	-
NovaSys PPO	$1,223.59	($80.29)	$1,143.30	-	-
Health Advantage POS	$1,079.95	($80.29)	$999.66	-	-
NovaSys POS	$1,079.45	($80.29)	$999.16	-	-
QualChoice POS	$1,191.43	($80.29)	$1,111.14	-	-
Health Advantage HMO	$1,060.49	($80.29)	$980.20	-	-
NovaSys HMO	$1,059.99	($80.29)	$979.70	-	-
QualChoice HMO	$1,118.87	($80.29)	$1,038.58	-	-
***High Deductible PPO**	$969.41	($80.29)	$889.12	$20.00	$909.12
Retiree & Medicare Spouse					
BCBS PPO	$953.69	($80.29)	$873.40		
NovaSys PPO	$953.17	($80.29)	$872.88		
Health Advantage POS	$847.59	($80.29)	$767.30		
NovaSys POS	$847.09	($80.29)	$766.80		
QualChoice POS	$929.63	($80.29)	$849.34		
Health Advantage HMO	$833.29	($80.29)	$753.00		
NovaSys HMO	$832.77	($80.29)	$752.48		
QualChoice HMO	$876.23	($80.29)	$795.94		
Retiree & Medicare Spouse & Child(ren)					
BCBS PPO	$988.47	($80.29)	$908.18		
NovaSys PPO	$987.97	($80.29)	$907.68		
Health Advantage POS	$877.93	($80.29)	$797.64		
NovaSys POS	$877.41	($80.29)	$797.12		
QualChoice POS	$963.41	($80.29)	$883.12		
Health Advantage HMO	$863.01	($80.29)	$782.72		
NovaSys HMO	$862.51	($80.29)	$782.22		
QualChoice HMO	$907.77	($80.29)	$827.48		

**Participation in the "HSA PPO (High Deductible)" plan and the Health Savings Account (HSA) are tied. A minimum mandatory member contribution of $20.00 per month to the HSA is required for participation in the NovaSys HSA High Deductible PPO plan. The Health Savings Account must adhere to federal guidelines. See far right column for total minimum monthly cost.*

Public School Employees - Retirees Medicare Primary

Effective October 1, 2004 - September 30, 2005, Self-Insured Health Plan

	Total Monthly Premium	School Contribution	Total Monthly Employee Cost
Retiree Medicare Only			
BCBS PPO	$464.63	($80.29)	$384.34
NovaSys PPO	$464.11	($80.29)	$383.82
Health Advantage POS	$414.51	($80.29)	$334.22
NovaSys POS	$414.01	($80.29)	$333.72
QualChoice POS	$453.25	($80.29)	$372.96
Health Advantage HMO	$407.73	($80.29)	$327.44
NovaSys HMO	$407.23	($80.29)	$326.94
QualChoice HMO	$428.03	($80.29)	$347.74
Retiree Medicare & Spouse			
BCBS PPO	$953.69	($80.29)	$873.40
NovaSys PPO	$953.17	($80.29)	$872.88
Health Advantage POS	$847.59	($80.29)	$767.30
NovaSys POS	$847.09	($80.29)	$766.80
QualChoice POS	$929.63	($80.29)	$849.34
Health Advantage HMO	$833.29	($80.29)	$753.00
NovaSys HMO	$832.77	($80.29)	$752.48
QualChoice HMO	$876.23	($80.29)	$795.94
Retiree Medicare & Child(ren)			
BCBS PPO	$645.33	($80.29)	$565.04
NovaSys PPO	$644.83	($80.29)	$564.54
Health Advantage POS	$575.61	($80.29)	$495.32
NovaSys POS	$575.09	($80.29)	$494.80
QualChoice POS	$629.53	($80.29)	$549.24
Health Advantage HMO	$566.19	($80.29)	$485.90
NovaSys HMO	$565.69	($80.29)	$485.40
QualChoice HMO	$594.43	($80.29)	$514.14
Retiree Medicare & Spouse & Child(ren)			
BCBS PPO	$988.47	($80.29)	$908.18
NovaSys PPO	$987.97	($80.29)	$907.68
Health Advantage POS	$877.93	($80.29)	$797.64
NovaSys POS	$877.41	($80.29)	$797.12
QualChoice POS	$963.41	($80.29)	$883.12
Health Advantage HMO	$863.01	($80.29)	$782.72
NovaSys HMO	$862.51	($80.29)	$782.22
QualChoice HMO	$907.77	($80.29)	$827.48
Retiree Medicare & Spouse Medicare			
BCBS PPO	$844.67	($80.29)	$764.38
NovaSys PPO	$844.15	($80.29)	$763.86
Health Advantage POS	$754.15	($80.29)	$673.86
NovaSys POS	$753.65	($80.29)	$673.36
QualChoice POS	$824.15	($80.29)	$743.86
Health Advantage HMO	$741.91	($80.29)	$661.62
NovaSys HMO	$741.41	($80.29)	$661.12
QualChoice HMO	$778.57	($80.29)	$698.28
Retiree Medicare & Spouse Medicare & Child(ren)			
BCBS PPO	$883.93	($80.29)	$803.64
NovaSys PPO	$883.43	($80.29)	$803.14
Health Advantage POS	$788.31	($80.29)	$708.02
NovaSys POS	$787.79	($80.29)	$707.50
QualChoice POS	$862.27	($80.29)	$781.98
Health Advantage HMO	$775.41	($80.29)	$695.12
NovaSys HMO	$774.91	($80.29)	$694.62
QualChoice HMO	$814.13	($80.29)	$733.84

Note: IRS Federal law states that Medicare eligible persons are not eligible for a Health Savings Account (HSA) and under our plan, they are not eligible for the NovaSys HSA PPO plan.

Public School Employees- COBRA

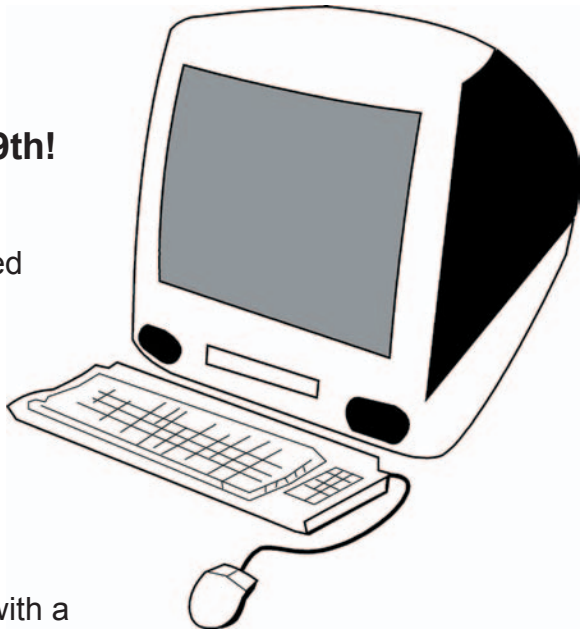
Effective October 1, 2004 - September 30, 2005, Self-Insured Health Plan

	*TOTAL MONTHLY PREMIUM	Health Savings Account	
		*HSA Mandatory Minimum Monthly Account Contribution	*HSA PPO Total Minimum Monthly Employee Cost
Employee Only			
BCBS PPO	$316.32	-	-
NovaSys PPO	$315.78	-	-
Health Advantage POS	$292.88	-	-
NovaSys POS	$292.34	-	-
QualChoice POS	$316.40	-	-
Health Advantage HMO	$284.20	-	-
NovaSys HMO	$283.70	-	-
QualChoice HMO	$298.70	-	-
***High Deductible PPO**	$261.14	$20.00	$281.14
Employee & Spouse			
BCBS PPO	$837.76	-	-
NovaSys PPO	$837.26	-	-
Health Advantage POS	$772.34	-	-
NovaSys POS	$771.82	-	-
QualChoice POS	$837.92	-	-
Health Advantage HMO	$748.18	-	-
NovaSys HMO	$747.66	-	-
QualChoice HMO	$788.54	-	-
***High Deductible PPO**	$671.20	$20.00	$691.20
Employee & Child(ren)			
BCBS PPO	$550.06	-	-
NovaSys PPO	$549.54	-	-
Health Advantage POS	$507.84	-	-
NovaSys POS	$507.32	-	-
QualChoice POS	$550.20	-	-
Health Advantage HMO	$492.26	-	-
NovaSys HMO	$491.76	-	-
QualChoice HMO	$518.28	-	-
***High Deductible PPO**	$444.97	$20.00	$464.97
Employee & Family			
BCBS PPO	$846.56	-	-
NovaSys PPO	$846.02	-	-
Health Advantage POS	$780.90	-	-
NovaSys POS	$780.38	-	-
QualChoice POS	$846.76	-	-
Health Advantage HMO	$756.70	-	-
NovaSys HMO	$756.18	-	-
QualChoice HMO	$797.16	-	-
***High Deductible PPO**	$678.20	$20.00	$698.20

**Participation in the "HSA PPO (High Deductible)" plan and the Health Savings Account (HSA) are tied. A minimum mandatory member contribution of $20.00 per month to the HSA is required for participation in the NovaSys HSA High Deductible PPO plan. The Health Savings Account must adhere to federal guidelines. See far right column for total minimum monthly cost.*

How Do I Enroll?

Web Self-Service Registration



Online Benefits Enrollment
Available at www.ARBenefits.org starting July 19th!

Beginning in the summer of 2004, EBD will implement a health insurance self service module through a system called "ARBenefits." This will be the preferred and recommended method of enrollment or change to your Plan during this open enrollment period, July 19th-August 31st. Completing this task online is the most efficient way.

The website for this online enrollment will be:
www.ARBenefits.org.

Public School Employees will be sent a letter this summer with a reminder about current plan enrollment selection and more specific instructions on how to use this new online process. There will also be online instructions at www.ARBenefits.org that will prompt you to register for a User ID and password. Once those are received you will have immediate access to complete your enrollment or change for the Oct. 1, 2004 – Sept. 30, 2005 plan year. After this open enrollment period, you will be able to make address and PCP changes through this website.

How Do I Enroll?

Paper Form Instructions

The Public School Employees Enrollment Form (#6000-f-1b) is used by new employees, employees wanting to change health plans, or for mid-year enrollments allowed under Cafeteria Plan rules.

These instructions will assist you in completing the Public School Employees Enrollment Form enclosed in this booklet. When the form is completed, please submit to your district School Business Official for processing. The instructions are organized to correspond with the numbered sections of the form.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your enrollment.

1. **Employee Information:** Please provide the demographic information requested.
   - If you do not wish to enroll in the health benefits, please complete section one (except Primary Care Physician information) and check the box in the heading beside the words "I decline coverage for myself."
   - Primary Care Physician (PCP) information is only required for members of the HMO or POS plans. Do not list a PCP if you are enrolling in either the PPO or HSA PPO plan. (The health plans no longer require a separate OB/GYN selection).

2. **Dependent Coverage Information:** Please provide complete information for each dependent you wish to enroll on your health plan.
   - If you are married and/or have other dependents but do not wish to enroll them on this health plan, please indicate by checking box beside the words, "I decline coverage for my dependents" in the header of section two.
   - Notice that the first dependent section is for SPOUSE information and subsequent blanks are for other dependents.
   - If dependent(s) is/are age 19 or over, they must be a full-time student to continue on the insurance. Please indicate whether they are a full-time student and provide documentation to the School Business Official at your district by using the student status verification form available from your district or EBD
   - If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents enrolled under your plan.
   - You may write over the gray words indicating where FIRST NAME, LAST NAME, (Middle Initial) and GENDER are to be written.
   - If you have more dependents than space allows, please attach an additional sheet containing the required information.

Continued on next page >>

3. **I Wish To Enroll In The Following Plan:** Indicate the plan in which you want to enroll and at what level of coverage.
    - Please check only ONE box in the HMO, POS, PPO or HSA PPO section to indicate your plan selection. You and your dependents must be on the same plan.
    - But also check the level of coverage you desire (Employee Only, Employee & Spouse, etc.) on the last horizontal box of section three.
    - Answer the questions below this section to aid in form processing.

4. **Other Medical Insurance:** In order to aid coordination of benefits with other health plans you carry, please provide complete information in this section.

5. **To Be Completed By School District:** Please return this completed form to your school district School Business Official for processing.

6. **Please Read Before Signing:** Read entire section then sign and date the form on the lines provided. We suggest you make a copy of this enrollment form for your records. Additional copies of this form may be printed from our website, www.arkansas.gov/dfa/ebd by clicking on the Benefits Library link.

STATE OF ARKANSAS
Department of Finance and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

Public School Employees
Enrollment Form

1. Employee Information: (please print)				❒ I decline coverage for myself
Last Name	First Name	MI	Gender	❒ Married ❒ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Work #:	
†Primary Care Physician:	PCP #	Current patient?		

†Primary Care Physician lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information:				❒ I decline coverage for my dependents
SPOUSE	FIRST NAME	LAST NAME	MI	GENDER
	Social Security #:	Date of Birth:		
	†Primary Care Physician:	PCP #	Current patient?	
DEP 1*	FIRST NAME	LAST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 2*	FIRST NAME	LAST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	
DEP 3*	FIRST NAME	LAST NAME	MI	GENDER
	Social Security #:	Date of Birth:	Full time student?**	
	†Primary Care Physician:	PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.
**To be completed for dependents 19 and over only. Please submit proof of student status.

3. I Wish To Enroll In The Following Plan:			
H.M.O	P.O.S.	P.P.O	*H.S.A. P.P.O.
❒ Health Advantage ❒ NovaSys Health ❒ QualChoice/QCA	❒ Health Advantage ❒ NovaSys Health ❒ QualChoice/QCA	❒ Ark. Blue Cross & Blue Shield ❒ NovaSys Health	❒ *NovaSys Health
❒ Employee Only	❒ Employee & Spouse	❒ Employee & Children	❒ Family

*As of the effective date of this plan year, are you eligible to participate in a Health Savings Account? ❒ Yes ❒ No
For clarification see www.ArkansasHSA.com or call 1-877-685-0655.

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒Yes ❒No
2) If Yes, what type of coverage? ❒ Medical ❒ Medicare, HIC # _____
If Medicare: Part A Effective Date / / or Part B Eff Date / /
If Medicare: Reason for Coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By School District:

School District #:	Name of School District:	
Employee #:	Hire Date:	Effective Date of Coverage:
If employee is transferring from another agency/district, please provide name:		

School Business Official Signature: _____

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the Insurer has approved the application and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered, to the health plan/insurer for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of the health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ **Date:** _____

When Can I Make Changes To My Plan?

Family Status Change Criteria

Unless you are a new employee or just became eligible for benefits, enrollment in a health plan, cancellation of enrollment in a health plan, or change to dependent coverage can only be made during the annual open enrollment period. Open enrollment elections have an effective date of October 1st. Typically, that is the only time to make a change to your health plan coverage.

Most health plan participants elect to have their health insurance premiums deducted on a pre-taxed basis. This provides significant tax advantages because you do not have to pay state or federal income taxes on the money you pay for insurance coverage, but that tax advantage brings with it a significant limitation.

If your deductions are taken on a pre-taxed basis, then you are limited to making changes to your insurance plan coverage only during the annual open enrollment period. That is unless you experience a "qualifying event" such as:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or dependent
- Change in status of employment affecting eligibility, either you or spouse
- Open enrollment under another employer's plan
- Judgment decree or order
- Gain or loss of Medicare/Medicaid eligibility

If you experience such an event, you have 30 days to notify your school district business official about this event and to request a change to your coverage. You cannot change health plans but you can cancel your coverage or change who is covered under your plan (add or drop dependents). You will be required to provide proof of the qualifying event and to complete a change form, either online or on paper. Your change will be effective the first of the month following your application for change.

If you have previously declined health coverage through the Public School Health Plan, and you experience a qualifying event as described above, you can enroll yourself and dependents in a health plan within 30 days of that event. Your enrollment will be effective the first of the month following your application for enrollment.

CHANGE FORM INSTRUCTIONS

Making a **change** OTHER THAN changing to a different health plan can be done online (www.ARBenefits.org) or by using the paper version of the *Change Form* (#6000-f-2).
The *Change Form* should be completed and submitted to your School Business Official for the following reasons:

- to add or delete dependents from health insurance plan during open enrollment or during the plan year according to Cafeteria Plan (IRS Section 125) rules which may allow a change in coverage status, i.e., Employee Only, Employee & Spouse, etc.
- to indicate the reason for making a change such as birth of a child, marriage, etc.
- to change retiree's mailing address or name

If the intent is to change health plans this can be done online (www.ARBenefits.org) or you may use the paper version of the *Enrollment Form* (#6000-f-1b).

Another form, the *Termination, Transfer or Retirement* (#6000-f-3) form is to be used to indicate termination or transfer to another district or retirement of an employee.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned for correction and could possibly cause a delay in processing the change.

The following instructions outline the process for completing the Change Form on page 46. The instructions are organized to correspond with the numbered sections of the form. Only use the Change Form for the purpose of making the changes indicated by the bullet points above.

1. **Employee Information:** Please provide the demographic information requested.
    - If not previously provided, please print your email address if you would like benefit updates and information mailed to you as the need arises.
    - Primary Care Physician (PCP) information is only required for members of the HMO or POS plans. Do not list a PCP if you are enrolled in the PPO plan.
2. **Change in Dependent Status:** If you want to add or delete a dependent from the Plan, please provide complete information for each dependent.
    - Write over the gray words indicating where FIRST NAME, LAST NAME, MIDDLE INITIAL (MI) and GENDER are to be written.
    - Please provide Social Security Number of the dependent, date of birth and whether the intent is to ADD or DELETE them from the policy.
    - If dependents are being DELETED from the policy, it is not necessary to indicate Primary Care Physician (PCP), PCP# or Student Status. If you are ADDING a dependent, please complete all of those blanks.

Continued on next page >>

- If dependent(s) is/are age 19 or over, they must be a full-time student at an accredited institution to continue on the insurance. Please indicate whether they are a full-time student and provide documentation to your chosen health insurance carrier. We have created a Student Status Form (#6000-f-3) for this purpose available on our website, www.arkansas.gov/dfa/ebd by clicking on the Benefits Library link.

- If applicable, please submit court orders for guardianship, court ordered insurance coverage, or adoption papers for dependents being adding to the policy.

- Please attach additional sheets if it is necessary to add more dependents than space allows. You may either attach another copy of the same form or otherwise provide the information requested.

3. **Change in Coverage:** Please complete this section to make any of the changes listed. Also, please provide us with a reason for the change, along with the appropriate date.

4. **To be Completed by Agency or School District:** Employees please do not complete this section. Your "SBO" or School Business Official will complete this section and forward to the Employee Benefits Division (EBD) for processing. Please do not send this form to EBD directly.

5. **Employee Signature:** Sign and date the form on the lines provided. We suggest you make a copy of this form for your records. Additional copies of this form may be printed from our website, www.arkansas.gov/dfa/ebd, by clicking on the Benefits Library link.

   Send the completed Change Form by August 31, 2004 to your School Business Official. Changes will go into effect on October 1, 2004.

STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.state.ar.us/dfa/ebd

Change Form
Status, Name and Address

1. Employee Information: (please print)					
Last Name	First Name			MI	❒ Married ❒ Single
Home Address	City		State	Zip Code	
SSN#	Date of Birth:	Home #:		Work #:	
If you would like benefit information sent to you by email, please print your email address:					
Primary Care Physician:	PCP #	Current patient?			

2. Change in Dependent Status (complete this portion if making any changes in dependent status):			
FIRST NAME	LAST NAME	MI	GENDER
Social Security #	Date of Birth	❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	❒ Add	❒ Delete
Primary Care Physician:	PCP #	Full time student?**	

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
****For dependents 19 and over only. Please submit proof of student status.**

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
❒ Employee Only ❒ Employee & Spouse ❒ Employee & Children ❒ Family ❒ Cancel Coverage ❒ Add Dependent ❒ Delete Dependent ❒ Name ❒ Address	❒ Birth - Date: _____ ❒ Death - Date: _____ ❒ Divorce - Date: _____ ❒ Marriage* - Date: _____ ❒ Other: _____

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ **Date:** _____

But I Have A Question

Frequently Asked Questions and Answers

ACTIVE EMPLOYEES

If I'm an active employee not currently participating in the Health Insurance Program, may I enroll now?

Yes. If you want health insurance coverage this next plan year, you must enroll during this enrollment period. Unless you or your dependents qualify under the following federal laws, you cannot enroll during the remainder of the school year, unless:

- You or your eligible dependents have lost other health insurance coverage through no action of your own.
- You have acquired a new eligible dependent through marriage, birth, adoption or placement for adoption.

NOTE: Voluntary termination from another plan does not qualify you to enroll in this plan.

Do I have to complete a new enrollment form this year?

Not if you want to remain in your current health insurance plan.

What if I want to change my health insurance plan?

Submit your completed enrollment form online or to your school's business office. Your district should provide you with the forms as well as the due date, which will be sometime in August. New referrals must be obtained when changing from one insurance carrier to another.

If I change to a new plan during enrollment, will I be subject to pre-existing condition limitations?

No. Therefore, it is not necessary to show proof of prior health insurance coverage upon application or change.

Are the network providers in my current plan remaining the same?

There are frequent changes in every network; therefore, please check the provider directories or – for the latest network information – call the plans or visit their web sites.

Do I have to select the same PCP for my entire family?

No. Each member of your family may select a different primary care physician (PCP). Female plan members under Health Advantage, QualChoice or NovaSys plans can seek gynecological care without a referral if the provider is in that company's network.

What is the difference between a "Pure HMO" and the POS plans offered?

A pure HMO offers no out-of-network benefits except in cases of dire emergency or special insurance company pre-authorized out-of-network referrals. An HMO requires a member to obtain a referral from their Primary Care Physician. If referrals are not obtained from the Primary Care Physician the claim will be denied. POS plans offer an HMO benefit when an insured stays in network with a PCP referral, but also offers reduced benefits when the insured seeks specialty services without a referral.

The POS benefit is generally designed for people that want the flexibility to access health care both in-network (with PCP referral) and out-of-network without obtaining a referral from the Primary Care Physician. The POS benefit allows you to go out-of-network, just remember that 60% of maximum allowable payment is not 60% of billed charges. The POS benefit can be used for members who reside out of state also, because you can use providers that are not in the network. The HMO is not designed for members who live out of state, as there are no benefits outside the network. Most networks are only statewide. There are a few exceptions to that rule if you reside in a border city such as Texarkana, West Memphis, etc. Please contact your specific HMO carrier to determine if networks are available to you in the border cities.

What is a PPO and how does a PPO differ from an HMO and POS?

A PPO is most like an Indemnity Plan. In a PPO Plan, a member has a separate deductible and a separate coinsurance for both in and out of network services. If the member stays in the statewide PPO network it is likely that the plan will pay a higher reimbursement than if the member accesses care outside the PPO network.

What is the difference between the PPO and the HSA PPO plans?

The deductibles are different and the HSA PPO plan requires participation in a separate HSA account. Also, the pharmacy benefit for the HSA PPO plan participants requires a $50 plan year pharmacy deductible for each person, then the same $5, $10, $25, and $50 co-payment structure applies. For the HSA PPO, the mental and behavioral health benefits are subject to the whole plan's deductible before benefits are paid. See the following sections in this manual for more details: What Each Plan Covers, Pharmacy Benefit and Mental/Behavioral Health.

Are my child's immunizations covered?

State mandated immunizations are a covered benefit for children up to age 18. Some adult immunizations are a covered benefit including the flu immunization. See wellness page in this booklet.

How can my children who are in college IN-STATE access my POS or HMO Plan?

Routine non-emergency medical services are paid according to “in” and “out-of-network” rules. A network provider located in the college town qualifies as “in-network,” just like a hometown in-network physician. We recommend your child select a PCP in their college town. Emergency services, regardless of the provider used, are paid “in-network.” Charges incurred at a school infirmary are not covered.

How can my children who are in college OUT-OF-STATE access my POS or HMO Plan?

Routine healthcare benefits for college students out-of-state will be limited or non-existent and the HMO would be the least favored plan for out-of-state college students. Health care benefits are available in the POS plan, just remember that the POS benefit reimburses at 60% of maximum allowable amount rather than 60% of billed charges after deductible is met. Therefore, for a college student out of state, this plan does provide some limited benefits. Call your health insurance carrier to inquire if a guest membership is available for out-of-state students. The PPO plan is the best plan to have for out-of-state college students.

If my PCP pulls out of the network I am enrolled in after the enrollment period, may I change plans?

Plan changes mid-year are rarely allowed. Only in cases of documented lack of access to providers will a mid-year enrollment be permitted. For example, in the event a county loses all of its network providers in a particular plan, a “special” re-enrollment would permit all plan participants in that county to select another plan. The decision to allow a special enrollment comes from the Employee Benefits Division (EBD).

LIFE INSURANCE

How do I enroll in the Supplemental Life program offered by USAble Life?

New employees will have 30 days from their hire date to enroll in the Supplemental Life program. You may apply for Supplemental Life even if you are not enrolled in the Health Plan. If you are currently insured by the Public School Employee group health plan, but have not elected Supplemental Life, you may make application by providing evidence of insurability. If you are not enrolled in the Public School Employee group health plan and wish to enroll in the Supplemental Life Plan you may make application by providing evidence of insurability. Please contact your district office to obtain a Supplemental Life application.

For how much Supplemental Life may I apply?

The Supplemental Life is bracketed by salary (see life insurance section in this booklet). Your district office can advise you on the amount you may carry.

COBRA PARTICIPANTS

May I change plans if I go on COBRA?

COBRA participants are eligible to change plans at "open enrollment." You cannot change plans in mid-year.

Are the same benefits offered to COBRA participants as to active employees?

COBRA participants have the same pharmacy and medical benefits as active and retired employees. Life insurance is not available to COBRA participants through this health plan. Contact USAble Life for life insurance conversion options.

FOR RETIREES - OR THOSE THINKING ABOUT RETIREMENT

(Please note: The Employee Benefits Division (EBD) has produced an "Enrollment Guide for Public School Retirees" in addition to this one for active employees. You may obtain a copy from EBD.)

May I change my insurance plan if I retire after August 31, 2004?

Plan changes can be made only at "open enrollment." If you have a life changing event that qualifies you for a "special enrollment" (such as marriage, divorce, death of spouse, etc.); then you can add or drop dependents within 30 days of that event.

What if I select COBRA rather than the retirement plan?

If you select COBRA you must stay on COBRA your entire eligibility period to qualify for insurance through the Retirement Program. **COBRA participants lose the life insurance benefit.** This benefit will not be reinstated when you go to the retirement group. EBD is your COBRA carrier and will bill you monthly. If your COBRA benefits are terminated for non-payment or late-payment, you will not be eligible for insurance through the retirement program.

How will my retirement premiums be billed?

Your premium will be automatically deducted from your retirement check every month. If your retirement check does not cover the premium cost, you can be set up on automatic bank draft to pay the premiums.

What if I have Medicare?

As a retired insured, you are eligible to continue your public school medical insurance after Medicare begins. When Medicare commences, it will become your primary coverage and claims will be filed with Medicare first. Please check with the health plan you select to determine how it coordinates with Medicare. Also, please remember that Medicare coverage is very limited. Most of your prescription drugs will be covered by your state prescription drug program.

Retirees eligible for Medicare must have both Part A and Part B.

Please refer to the premium rate pages for Medicare Eligible and Non-Medicare Eligible Retirees for further cost information.

Complaints And Appeals Process

Overview

HMO and POS Appeals Process

(for Health Advantage, NovaSys and Qualchoice)

Authority of Employee Benefits Division

Employee Benefits Division (EBD) shall have authority and full discretion to decide all questions arising in connection with coverage under the Plan, including interpretation of Plan language, and findings of fact with regard to any such questions.

DEFINITIONS:

Complaint. An expression of dissatisfaction either oral or written.

Appeal. A request to change a previous decision made by the Claims Administrator. Appeal as used in this Attachment A does not include appeals regarding termination of coverage. Appeals for termination of coverage are subject to the appeals procedure set out in Section 4.2.3 of the Summary Plan Description.

HOW TO SUBMIT A COMPLAINT OR APPEAL:

Complaints or Appeals may be submitted in writing to your chosen Claims Administrator.

For Health Advantage:
Health Advantage
P. O. Box 8069
Little Rock, Arkansas 72203.
Attention: Appeals Coordinator

For NovaSys:
NovaSys Health
P. O. Box 25224
Little Rock, Arkansas 72221
Attention: Appeals Coordinator

For QualChoice of Arkansas:
QualChoice of Arkansas
10825 Financial Centre Parkway, Suite 400
Little Rock, Arkansas 72211
Attention: Appeals Coordinator

Members will not suffer any sanctions or penalties resulting from submitting a Complaint or Appeal.

ORAL COMPLAINTS

A Member having a Complaint regarding any aspect of the Claims Administrator may contact a Customer Service Representative specific to the chosen Claims Administrator.

- Health Advantage 800-843-1329
- QualChoice of Arkansas 800-235-7111
- NovaSys Health 888-870-8103

The Customer Service Representative will assist in resolving the matter informally. If the Member is not satisfied with the resolution, a written Complaint may be submitted. A Member is not required to make an oral Complaint prior to submitting a written Complaint.

WRITTEN COMPLAINTS

The Claims Administrators will acknowledge receipt of a written Complaint within seven (7) working days. A thorough investigation of the Complaint will be made and the Member will be mailed a response with resolution. If the Claims Administrator is unable to resolve the written Complaint within thirty (30) working days due to circumstances beyond its control, the member will be provided notice of the reason for the delay before the 30th working day.

HOW TO FILE AN APPEAL

An appeal must be submitted in writing to the chosen Claims Administrator at the previously documented addresses and must identify a specific action or determination of the Claims Administrator for which the Member seeks an appeal. The Claims Administrator will acknowledge receipt of the appeal within seven (7) working days.

The appeal must be made within 180 days from the date of the notice of the Claims Administrator's determination that the Member is appealing. At any stage of the appeal, the Member may designate, by signed written notice to the Claims Administrator, a representative to assist in making the appeal. Any such designation shall constitute authorization for the Claims Administrator to release any information or records regarding the appeal or the Member to the designated representative.

First Level Review

A person or persons not involved in the initial determination will review the appeal. The Claims Administrator may request additional information from the member in order to review the appeal. The Claims Administrator will respond in writing within 30 days after receipt of all pertinent information. If the Claims Administrator is unable to resolve the appeal within 30 working days, the Member will be notified of the delay on or before the 30th working day. The time-frame for resolving the appeal shall not exceed 45 working days. If the outcome is adverse to the Member, he/she may appeal to the second level.

Second Level Review

Health Advantage

If a member is not satisfied with the determination received on the first level of appeal, the member may appeal to a Second Level Review Committee. The appeal must be received within 60 days of the notification of denial by the First Level Review. A committee established by Health Advantage shall conduct the second level of review within 30 working days after receipt of the Member's appeal to the second level. The committee shall consist of persons who were not involved in the initial determination or First Level Review; although such person(s) may appear before or communicate with the committee. The committee will meet and make a determination of the Member's appeal. The Member has the right to appear in person, attend via teleconference, or be represented by a person of his/her choice.

NovaSys Health

If a member is not satisfied with the determination received on the first level of appeal, the member may appeal to the Appeals Coordinator II. The appeal must be received, in writing, within sixty (60) days of the notification of denial by the First Level Appeals Coordinator. The Appeals Coordinator II will forward the appeal to NovaSys Health's Appeals Committee, consisting of persons not involved in the initial determination or the First Level Review; although such person(s) may communicate with the committee. The Appeals Committee will review and make a determination of the Member's appeal within thirty (30) working days after receipt of the Member's Second Level Appeal.

QualChoice
If a member is not satisfied with the determination received on the first level of appeal, a second level appeal may be made in writing to QualChoice. A review of the second level appeal will be conducted within 30 working days after the receipt of the Member's appeal to the second level. The appeal will be reviewed by one of the Plan's Physician Advisors who was not involved in the initial determination or the First Level of appeal; although such person(s) may be communicated with during the review process.

Final Level Review

If the outcome of the Second Level Review is adverse to the member, he/she may appeal to the Plan Administrator. Such appeal should be mailed to: Employee Benefits Division, Attention Appeals, State of Arkansas, Department of Finance and Administration, P.O.Box 15610, Little Rock, AR 72231-5610. The decision of the Plan Administrator will be made within 30 days of receipt of the written appeal and is final and binding on the Plan and the Member.

Expedited Appeal

An expedited appeal may be requested related to a claim involving urgent or ongoing care. The request may be made by telephone followed by written confirmation or in writing. If a member or someone designated by the Member and acting on behalf of the member requests an expedited appeal the Claims Administrator's Appeals Coordinator will notify the Member or the Member's authorized representative and the member's treating health care professional of the determination of the expedited appeal in accordance with the medical needs of the case and as soon as possible, but in no case later that 72 hours after the Appeals Coordinator receives the expedited appeal.

Authorized Representative
A Member may have one representative and only one representative at a time to assist in submitting a claim or appealing an unfavorable claim determination. An authorized representative shall have the authority to represent the Member in all matters concerning the Members' claim or appeal of a claim determination. If a Member has an Authorized Representative, references to "Member", "Your" or "You" in the plan SPD refer to the Authorized Representative.

Designation of Authorized Representative
One of the following persons may act as a Member's Authorized Representative:

1. An individual designated by the Member in writing. (The Claims Administrator may require this designation be documented on the Claims Administrator's approved form);
2. The treating provider, if the claim is a claim involving urgent care, or if the Member has designated the provider in writing. (The Claims Administrator may require this designation be documented on the company's approved form);
3. A person holding the Member's durable power of attorney;
4. If the Member is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Member by a court of competent jurisdiction; or
5. If the Member is a minor, the Member's parent or legal guardian, unless the Company is notified that the Member's claim involves health care services where the authorization of the member 's parent or legal guardian is or was not required by law and the Member shall represent himself or herself with respect to the claim.

Term of the Authorized Representative

The authority of an Authorized Representative shall continue for the period specified in the member's appointment of the Authorized Representative or until the member is legally competent to represent himself or herself and notifies the Company in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative

1. If the Authorized Representative represents the Member because the Authorized Representative is the Member's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
2. If the Authorized Representative represents the Member in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company/Carrier shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
3. If the Authorized Representative represents the Member in connection with the submission of a post-service claim, the Company/Carrier will send all correspondence, notices, and benefit determinations in connection with the Member's claim to the Member, but the Company/Carrier will provide copies of such correspondence to the Authorized Representative upon request.
4. The Member understands that it will take the Company/Carrier at least thirty (30) days to notify its personnel about the termination of the Member's Authorized Representative and it is possible that the Company/Carrier may communicate information about the Member to the Authorized Representative during this 30-day period.

PPO & HSA PPO Appeals Process

(for Blue Cross Blue Shield and NovaSys Health)

To Appeal A Claim.

1. If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. You may request a review of a denial of benefits for any claim or portion of a claim by sending a written request to the Appeals Coordinator:

   - Arkansas Blue Cross and Blue Shield / A Mutual Insurance Company
     Attention: Appeals Coordinator
     P.O. Box 2181
     Little Rock, Arkansas 72203-2181
   - NovaSys Health
     Attention: Appeals Coordinator
     P. O. Box 25224
     Little Rock, AR 72221

   Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

2. In preparing your request for review, you or your duly authorized representative will have the right to examine documents pertinent to your claim. However, medical information can be released to you only upon the written authorization of your Physician. You or your representative may submit, with your request for review, any additional information relevant to your claim and may also submit issues and comments in writing. A complete review will then be made of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require extensive review. A final decision will be sent to you after no longer than one hundred twenty (120) days.

3. Subsequent to the determination of the Appeals Coordinator, you can appeal to the Plan Administrator, EBD, Post Office Box 15610, Little Rock, AR 72231.

4. The Plan Administrator acting on behalf of the Plan shall have authority and full discretion to determine all questions arising in connection with your benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions shall be conclusive and binding on the Plan and you subject to the grievance and appeals procedures as outlined in the plan SPD.